IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MINNESOTA

KEVIN SCOTT KARSJENS,
DAVID LEROY GAMBLE JR.,
et al.,

Plaintiffs,

v. No. 11-3659 (DWF/JJK)

LUCINDA JESSON, DENNIS
BENSON, et al.,

Defendants.

VIDEO DEPOSITION OF JAMES HAAVEN

Taken in behalf of Plaintiffs

Friday, October 17, 2014

BE IT REMEMBERED THAT, pursuant to the Federal Rules of Civil Procedure, the deposition of JAMES HAAVEN was taken before Marilynn T. Hoover, a Certified Shorthand Reporter in Oregon; on Friday, October 17, 2014, commencing at the hour of 9:17 a.m.; at BEOVICH WALTER & FRIEND, 1001 S.W. Fifth Avenue, Suite 1200, in Portland, Oregon.

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ALSO PRESENT: Mr. Mick Irwin, videographer

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JAMES HAAVEN,

called as a witness, being duly sworn on oath, was examined and did testify as follows:

Would you please state your name for the record.

A. Yes. James Lee Haaven.

Q. And so in what years did you perform annual evaluations for MSOP?

A. Again, I don't -- I believe the first one was either -- it was 2006, I believe; and then we did a review every year except 2008, I believe, is the one year that we didn't.

Q. And do you know why there was no review that year?

A. That year was because there was a major change, a shift organizationally, as to under what governmental body that MSOP would fall, as well as a pretty significant change of internal leadership.

So it was more a logistical issue, just trying to organize such a thing and...

Q. And -- Well, okay. First I'd like to cover some of your background.

Can you give me a -- Describe your educational background for me.

A. My educational -- Well, let's see. I graduated with a bachelor's of science degree in civil engineering in 1966 and then attended a community college for 15 credits but did not finish a degree in psychology. I then completed a degree, a bachelor of arts degree, in sociology in 1973. In 1975, I completed a master's of arts degree in behavioral science from Pacific Lutheran University in Tacoma, Washington.

Q. And outside of those degrees, do you have any sort of professional certificates or licenses?

A. I was certified -- a certified clinician here in the state of Oregon, but I don't believe I'm certified at the moment. I was just checking my -- whether I had paid my dues for this year yet, so I'm not sure. Since I don't do any work in this area, I don't pay any particular attention; but I was certified as a certified clinician. Those are the only certifications that I have.

Q. And have you had any sort of training on sex offender treatment specifically?

A. Yes. Extensively through conferences, and I've been actively engaged with the Association for Treatment of Sexual Abusers since its founding; and so I'm actively engaged in all of the training processes through that, as well as many other conferences I've attended through the years.

Q. So outside of ATSA, are you a member of other professional organizations related to treatment?

A. Well, National Association of Persons with Developmental Disabilities is the only other organization that I'm a member of.

Q. And have you ever published any papers on the -- in the area of sex offender treatment or...

A. Yes.

Q. And what were the -- How many of the papers?

A. You know, I don't know for sure, but I'm going to guess it's at about eight or nine. One -- Almost all of those were -- One -- About ten: One informational packet, the rest were articles, and one was a book.

Q. And what was the book on?

A. The book was just -- I think it was called Model Residential Program. It was written in 1990, Residential -- Model Residential Program for Persons with Intellectual Disabilities, with sexual offending issues.

Q. And since 1990, has -- have you updated that book?

A. Not that book, no.

Q. And what are the -- You said you'd published other --

A. Yes. I've published other chapters in books, regarding treatment issues, assessment issues. I'm also one of the co-authors and primary authors of the development of a new risk assessment tool called Armadillo S.

Q. Armadillo S?

A. The Armadillo S.

Q. And what does that measure?

A. Again, it's a risk management tool for persons with intellectual disabilities, with sexual offending issues.

Q. Is that test still in the developmental stage or is that used anywhere?

A. It is now used here in the United States as well as other countries. The Web site for it is

Armadillo.net.

Q. And how is that different than other -- Is this an actuarial test?

A. No, it isn't, actually. It was -- Again, it was designed as a management guideline assessment process to assist people in how to develop treatment strategies and support systems for persons with these particular types of problems. In the process, of course, some of the authors of the tool, as well as other persons around the country, have now used that tool in trying to see if it's also predictive -- has predictive validity. There's only been three studies done in that regards -- somewhat, again, small studies; so at this point we could not say that it's a predictive instrument yet.

Q. And who are the co-authors of that, the Armadillo S?

A. Doug Bower, and William Lindsay, and Joseph Skadalin, S-K-A-D-A-L-I-N, and Freese, Mike Freese, and Frank Limbrick. They're all from other countries; so I say by name, yet I've never met -- I've only met two others, two of them.

Q. And so what -- Why did you -- What

Q. And do you know how many programs use the Armadillo?

A. I don't. They use it in a broad range of different ways. I do know that it's -- there's certainly a number of states that use this. I do consulting up in New York, Pennsylvania, certainly all throughout New Mexico. It's used up in Canada in various areas. In fact, I'm doing trainings in that regard next week in Toronto. It's used rather extensively in Australia and New Zealand. It's also been introduced to Scandinavian countries. It's used in the United Kingdom, where I've done training.

So, again, I really don't know, but it's -- it's one of the few tools available for this type

of issue in this area, so it's...

Q. Okay. Do you know if the Minnesota Sex Offender Program uses the Armadillo S?

A. They don't. They're familiar with it, but the reason that it's not as applicable in this regard is it's primarily used as a risk management tool for persons that are moving to community settings; so that's when it becomes much more applicable. Within institutional settings, it really doesn't give significant useful information, so that's why it's not used there.

Q. Okay. And so, now, as I understand it, you have a private practice?

A. I do consulting as my private practice, yes --

Q. And what --

A. -- and training.

Q. And consulting on what specifically?

A. Almost all of my consulting now is pretty much exclusive to special needs populations, persons with -- especially with intellectual disabilities and persons with mental health issues and other types of psychiatric disorders.

Q. And is your consulting on those populations generally or populations who are in

prisons or some sort of confinement?

A. All settings. All variety of settings.

Q. And prior to your current consulting practice, did you work in this field?

A. Yes.

Q. In what?

A. I worked about -- I was about eight years at the -- at Western State Hospital, where I was clinician and then also became program director of outpatient services. And, again, that's where I initially started specific work, working with issues around sexual offending issues.

And then I was the unit director for two programs in the state of Oregon, at Oregon State Hospital: One program for 24 years; and the other program, that I think I just previously told you about, due to the class action suit, I inherited and I had that for about 18 years in parallel with the other program. Both of those programs are focusing primarily on persons with intellectual disabilities; and most of those folks, the focus was sexual offending issues.

Q. So for -- So for the Western State Hospital, that -- those were special needs people with --

A. They were special needs.
Q. And also some with sex offender issues?
A. Yes.
Q. And the same for the Oregon State Hospital?
A. Yes.
Q. And when -- You were eight years at Western States Hospital. Do you -- When did you start there?
A. Must have been around 1972, I think, is when I started. Between '72 and 1980 is when I was there.
Q. And Oregon State Hospital was after that?
A. Was after that, until 19 -- until 2004.
Q. And so how -- how did you come to be an evaluator for the MSOP program?
A. Since I had been involved with the -- with the class action suit in Washington that was initiated in 1994, was my initial experience with civil commitment programming. After that, I became more involved with doing some consulting training in other civil commitment programs. It was just sort of a collection of civil commitment programs -- I'm trying to think now.

Ridge program wanted to have an advisory team; and so, in looking at who might present the expertise needed, that they were looking for, they identified three of us. And primarily my focus was in the area around special needs programming, thing of that sort. And so we just sort of came together as such and were invited to be part of that; and since then, we have done some other evaluations as a team.

Q. So is it the same group of people you work with who evaluate the Wisconsin program and the Minnesota program?

A. Yes. We don't evaluate the Wisconsin program now. We did, I believe, for either five or six years; I'm not sure. I think their last evaluation there was four years ago, I believe.

Q. And do you know why -- Let me step back.

Do you know if that program is still receiving annual evaluations?

A. I don't believe so. I believe ours was the last -- who knows? I don't know all the reasoning why; funding issues and the like.

But I might add, also, that the last year we did an evaluation, they also expanded the advisory group to two other additional people, a psychiatrist and another psychologist.

Q. And who -- So who were the people on the original Wisconsin --

A. It would be Robert McGrath and William Murphy who were the other two evaluators of MSOP.

Q. And do you know who the additional two people were that were added?

A. It was a Dr. Stephen Hucker, and Robert Hare was the psychologist -- the other psychologist.

Q. And is that H-A-R-E?

A. H-A-R-E.

Q. And so is that from the Hare psychiatric --

A. Yes. PCL-R.

Q. PCL-R. So for the Minnesota program, do you recall, was it something that MSOP contacted you or...

A. I was -- I was asked to come to do training at MSOP for the special needs program on the St. Peter side in 2005, I believe. Plus, I had been involved with MSOP -- in fact, I did initial training for special needs population when it was first developed back in 1995, I think, something of that nature. I can't remember the first year. So I was sort of known in that area.

So I was brought in in 2005 for the S -- I

think they called it the special needs services program of the MSOP at the time; and, in doing so, they also asked me some specific questions to respond to. When I did, I then shared with them what we do in some of the other civil commitment programs: That, by having a team look at this, you get a broader perspective. And it was from those discussions that they then asked -- invited us as a team to return from then on. So I think -- I think it was 2005 I came in; and 2006, I think, was our first time as a team together.

Q. And do you remember specific --

Q. BY MR. GOODWIN: And so what other

programs do you evaluate, outside of MS -- Go ahead.

A. MSOP is the only site that we're doing right now, routinely, yearly; but we have done -- and, again, we haven't -- The ones that we've done together, we've did approximately six years in a row, six to seven years at Wisconsin. We did one yearly evaluation for New York. We did a yearly evaluation for Kansas. I did evaluations for the special needs part of the Washington program.

And, again, they -- they can speak to -- because they have -- Bob and Bill have also done some yearly reviews; and, again, I -- they would have to respond to that -- for several years in Florida. I did training and consultation in Florida but was not part of a yearly, annual evaluation.

Now, I've done trainings in other civil commitment programs and consultation; but, as far as an actual evaluation report, that is -- I've only been involved with the states I mentioned, which was New York, Kansas, Minnesota, Wisconsin, and Washington.

Q. And so what other states have you consulted with, related to sex offender --

A. Yeah. Where I didn't do program reports, like I said, one was Florida; Arizona; Texas, which

is an outpatient program; and Virginia. And let me think. I think I believe that's what I -- I don't recall.

Q. So for the Minnesota program specifically, was it something that the program initiated, it

sounds like, and came to you and said, "We'd like an evaluation"? Or is there some sort of statutory requirement that you're aware of that they -- the basis for --

MR. IKEDA: Objection. Foundation.

THE WITNESS: I'm not familiar with if there was any.

Q. BY MR. GOODWIN: Okay. So how about -- Can you walk me through the process of what you do as part of the evaluation, how that works.

A. Well --

Q. Excuse me. As it relates to MSOP specifically.

A. Yes. And the way in which we do this is we, each year -- again, we're told we're invited, if we're going to be returning to the process. If so, then a meeting is set up, usually with the -- initially with the clinical executive director. And then to decide as to, again, what is going to be the structure of that, the days are going to be the same days, same types of site visits, where the site visits will be at, also what we feel is the areas that we want to explore. And, for the most part, we -- we dictate, you know, as to where the focus of the attention is going to be. There might be -- The

clinical director may ask -- there's some particular areas of concern that they have that they'd like us to look at, so they would ask us if we could accommodate that in the process.

So that's kind of how it's initially set up. And then, from there, they then set up whatever logistics we ask for as to where we want to visit, where we want to go, time periods, things of that nature.

Q. And are you currently planning on performing an evaluation for MSOP for this -- this year?

A. Yes, in December.

Q. And, as part of that evaluation, have you started the process of contacting the clinical executive director yet?

A. Not as to the actual content of where we're going to put our focus, no. Only the days that we're going to be in and how many days at each site.

Q. So for this year, are there any specific areas that you've been asked to look at?

A. No.

Q. And for -- Do you recall other specific areas you've been asked to look at regarding MSOP?

A. Yeah. For the most part, the requests from MSOP to us of specific things to look at or things to respond to are actually very -- usually very limited. And so I'm sort of going from memory here: It seems like -- like once there was a question, could we look at -- Do we think that MSOP should do psychosexuals on -- with individuals who -- psychosexual evaluations with persons who have not been committed to the civil commitment program? There was questions like, Should we integrate persons that have behavioral problems into one area or mix them within units? So it's questions like that, but I would say it's no more than maybe four or five requests over the six, seven years, that I can remember specific to that. It's usually left up to us: Where do we want to explore the coming year?

Now, we do that by looking at our reports, the areas that we think need to be followed up on. If there's areas that we thought that there might have been some areas of concern, we want to see if changes have taken place. So we pretty much set the agenda. In fact, we totally set the agenda.

Q. Okay. And so, outside of meeting with the executive clinical director, do you meet with other staff?

A. Not necessarily. We might coordinate some logistical things, like through the clinical director at St. Peter's -- Haley Fox, possibly, or Tom Lundquist, in Moose Lake. But, for the most part, the organizing of the evaluation process is through the clinical executive director, who of course is working through the executive director, Nancy Johnston; but, almost exclusively, our discussion is with the clinical director.

Q. But once you're actually into the evaluation process, as part of that evaluation, do you have formal meetings with clinicians who -- who deal with clients --

A. Yes.

Q. -- or other people?

A. Yes. We are given full access to any information or any persons or any settings, and so we meet with the a wide array of folks -- administrators, clinicians, as well as we meet with clients.

Q. So, as far as on the administration side, so you meet with clinicians and -- If you can recall the role -- the roles of people you meet with?

A. We meet with folks at all levels. We want to meet with manage -- super -- clinic -- clinical

supervisors; we meet with the frontline clinicians; we meet with security staff, residential staff. So we try to touch all levels of engagement that persons are going to have with the clients.

Q. So, for instance, the clinicians you meet with, how -- who selects which clinicians you sit down with?

A. Well, we don't select a particular person, but we select groups, and we also decide how we want to meet with them. So, for instance, sometimes we might not want to meet with some people individually. Sometimes we asked if we could meet with them as groups. Sometimes we'll say we want them as a group but we don't want supervisors present. So we do it in a variety of ways, kind of depending on how we think we're going to get the best information.

And it's also somewhat fluid. Once we get to MSOP, the schedule may be modified and changed -- in fact, almost always is; because, as we see particular issues, concerns, or contradictory information, we want to interview and review more situations and individuals; and so we'll make those requests, of which MSOP always responds.

Q. So for a situation where you would say you

want to meet with a group without the supervisors present, what -- what would trigger you to want to meet without the supervisors there?

A. Because we want them to be able to feel that they can share information openly and not feel any sort of pressure in that regard. Even though they're not necessarily stating they feel pressure, we know that anytime your boss is sitting in the room, you're not going to talk the same way that you would otherwise; so we try to get a range of different ways that we can get information.

Q. So do you recall, from any of those meetings specifically where you have said you don't want to have supervisors there, where there's been any discussion about concern about those, say, clinicians, that their supervisors are -- they would say something that would upset their supervisors?

A. I really can't speak to what would be upsetting to their supervisors. Certainly, in doing a process like that, they're going to share some information that the supervisors, I'm sure, sometimes would rather not be said -- I mean, for sure.

Q. Okay.

A. But it's a -- it's a quite open process.

I think, over the years -- that's the other strength of coming back yearly, that there's a trust in the process. We do not ever share names or particular information shared by an individual, As we share with them openly that what we're looking for is broad themes. So, for instance, if someone says that there's a problem in a particular area, we don't necessarily take that as fact. We then start checking to see: Is this a theme of other people having the similar kinds of issues? And...

Q. And you said you also meet with clients as part --

A. Yes.

Q. -- of the evaluation? So how -- how are the clients selected that you meet with?

A. We do it in various -- We've done it in various ways. It's usually as a group, small groups. I believe the last time we did it a little differently. We asked to see -- There's a -- They now have sort of a representative kind of government process, and so we asked if we could talk with that group. We felt these are folks who are rather assertive and we could have opportunity again to speak with them. And, again, when we do that, we do that without staff presence.

Q. And do you meet -- Do you make it a point to specifically meet with clients in, say, the alternative program or outside of the conventional treatment program?

A. Again, we try to get -- yeah, we try to get a mix. I -- My attention particularly is focused on the special needs area; and so I do, maybe more than in some of the other areas, sort of float around the units and have more what I'd call informal contact with clients and staff. I find that's a better, more useful way of trying to gather information, working with special needs populations.

Q. So, at this point, since you've been there a couple of years, I assume the people recognize you and approach you?

A. Everybody recognizes -- Oh, yes. It's, "He's back."

Q. You're probably pretty popular while you're there.

A. That's good and bad.

Q. And so -- And then, as part of the client review, I know you meet with the clients, and then do you review client files? Is that part of the process?

A. Now, we do, but not as one might in, say,

what you'd call a certification or accreditation process. And the reason for that is that we're looking more specifically at sort of the big ticket items. For instance, are the plans reflective of the assessments? Are the things that they're working on and measuring for progress related to things that have been identified within the plans?

So we will make some probes into some of the charts on our visits in that regard, but we don't really do a chart audit per se; because there also is another level of a licensure or -- of where there is chart auditing. And so, you know, we trust that they can do that much better than we can, in a very limited amount of time we're trying to do it, really, three and a half days. But, for what we need to do and what we think is important for what we're attempting to do on the overall effectiveness of the program, we do make probes and spot checks of the charts.

Q. And you just mentioned that you're there generally for three and a half days; is that --

A. Well, when I say three and a half -- We're actually there for the whole week, but the last day is a debriefing of the -- from our -- what we've seen, sort of some of the broad issues that we've

seen. We debrief with the clinical director and the executive director individually. So it really leaves four days, and part of that day is traveling between St. Peter's and Moose Lake. So I'd say three and a half, for sure, full days; three and a half to four days, where we're on site.

Q. And do you feel like that's enough time to give the program an --

A. Yes.

Q. Are you familiar with other sex offender treatments programs that are accredited by JCAHO?

A. You know, I can't specifically state who is at this point. I don't know. There's -- I believe there is, but they are very few that

actually fall under JCAHO.

Q. Are there any other accreditation entities that would apply to a program for sex offender treatment?

A. Well, it depends. Sometimes states -- states have their own internal requirements for programming. I know that -- I think Minnesota has some of its own licensure requirements. So every state may have its own internal licensure systems. We try to stay away from the things that are already being done, especially if it isn't really meeting the need that we need for the more broader scope questions.

Q. And what would be the benefit of accreditation of a program?

A. The part that is problematic is that, even under Joint Commission, no one has come up with an accreditation system for person -- for programs specific to sex offenders, that are high intensity programs of this kind. I mean, this is a rather unique group, a unique mental health situation, in a sense. And, quite frankly, being involved in a program, even under a class action suit at the Oregon State Hospital, that was under the Joint Commission standards, they basically threw up their

hands and said, "We really don't have accreditation standards." So it's very limited right now.

So there are places that do have some accreditation systems, especially Canada and the U.K. So then the question is: Is that a good thing or not? I guess I'm not really the best person to decide that, because I haven't worked actively. My other -- The other two evaluators on this team have been engaged actively in those two systems in Canada and the U.K. and have a better insight. I would only have opinions; and, quite frankly, I don't believe that it's useful to share.

Q. So it sounds like it doesn't come as a big surprise to you that MSOP is not accredited?

A. Not at all, no. In fact, it would be a bit of a surprise if it was, considering the difficulty in how you do -- how you pull that off.

Q. But did you say the Washington program is accredited?

A. The Washington program, I don't believe, is at this point. And I'm not sure -- and, again, the other -- one the other evaluators may -- know but it seemed to me that the New York program was; but, again, very few.

Q. And so after having spent some time evaluating the Wisconsin program and the Minnesota program, what is your understanding of why Wisconsin has been able to successfully treat and release patients, whereas Minnesota has not?

A. Well, there's -- there's many, many different factors. First of all, this is a difficult group to place, and so you have to have buy-in at all levels of government and you have to have -- you also have to have a system that can accommodate the movement to the community. And so it, depending on those variables, can have an effect.

Wisconsin's process is a one-tier process, versus Minnesota, which has a two-tier process of review, to be able to move out into the community. So it, by the very nature of that, usually will lend itself to a much higher threshold to which someone can actually move into the community. So that's one piece.

The other part of it of course is just the politics of the problem itself: Being able to find

placement in the community and get cooperation within the community to which that placement can take place, including other -- what I'd call step-down agencies, things of that nature, that will take these folks.

So there's a lot of different pieces that go into it; so as to exactly why the -- I don't know. They certainly put a lot of effort and funding specifically into that, as well as statutory process to assist and facilitate that happening in Wisconsin. As to the actual programming, I did not see necessarily a change of programming that made the difference. I thought their programming was pretty much the same as it was before, from when they were moving very few people to where they were moving more people -- not, again, a large amount, but more people. The programming itself, I don't think, was almost -- it was secondary, from what I could -- from what I could observe.

Q. So you'd mentioned that politics is sometimes an issue here.

Are you aware of how politics in Minnesota -- Is there -- In your opinion, do politics override the clinician -- the therapeutic decisions?

MR. IKEDA: Object to the form.

Foundation. Speculation.

THE WITNESS: Yeah.

Q. BY MR. GOODWIN: You can answer if you can.

A. Yeah, I have no -- I really have no guess on that.

Q. Is there a -- As part of the annual evaluation, is there a written goal or objective to the evaluation you do for the MSOP?

A. No.

Q. So what do you understand the purpose of the annual evaluation for MSOP to be?

A. MSOP is inviting us to come in and take a look to see if they're operating within best practice standards within our field. And if there are particular things -- in other words, are there particular strengths that they're demonstrating that should not be eroded; and, number two, are there particular barriers to providing appropriate -- best practice treatment, as well as movement through the programs. That's our -- our overall. So it's -- it's a pretty broad review, but -- in other words, is this an effective process to actually accomplish the goal of what the MSOP is trying to accomplish?

Q. And do you think that this is an effective

process to achieve the goal of what MSOP is trying to accomplish?

A. Yes, I think it is, considering there's barriers -- many barriers in the way of the success that everybody wants to have.

Q. And what are those barriers that you see?

A. Well, I think, again, that gets kind of back to the evaluation report. We've identified within MSOP what we see as some of the barriers, you know, limitations, and those have been articulated within those evaluations. And then of course there's the external barriers, over which we have no control. Like I say, the review process is a bit different in Minnesota than other states.

Q. BY MR. GOODWIN: As far as you know, has MSOP ever successfully treated and released a patient from its program?

A. They've released -- They've released someone from the program. And so when you say "successfully," I think the process worked as it should. That particular -- That one particular

person ended up back in MSOP, but those are other issues; but I think the process -- yes, I think, where it -- where it happened, it worked; you know, it was appropriate.

Q. BY MR. GOODWIN: Well, so are you familiar with the -- and without getting into the whole legal process of it -- but are you aware that there's the full discharge and then there are provisional discharge options for a patient that's in MSOP?

A. Um-hum.

Q. But, to date, MSOP has not been able to fully discharge any patient. Is that a surprise to you?

A. Not a surprise, no.

Q. Are you -- Are you aware that there's a female patient in the MSOP program?

A. Yes. Yeah.

Q. And are you aware that she is housed in a unit with other male sex offenders?

A. Did not know that until I read about it in

a newspaper thing, I believe. And, in fact, when I got that -- In fact, I realized that when I saw -- went through the e-mails that I think is attached. I contacted my -- my other evaluator friends and said, "Have you heard about this? What about that?" you know.

So did we know that there was a female? We did, vaguely, that there was an individual. We -- I, quite frankly, assumed, at the time, that that was part of the St. Peter's facility of this -- the hospital side, of where this person was. So, in fact, in that e-mail, I believe I even asked: "I'm confused. Why did we not ask where this person was living? And number two, conditions?" Because it stymied me as to how did this, in a sense, get past us? And so that question was raised.

Q. And in -- And what was your conclusion? How do you think that happened?

A. I don't know. I don't know.

I mean, as to why we did? Because we're looking at broad issues, for starters; and so when you hear "a person" in a particular -- I guess we just didn't focus in on that particular client. We look at sort of the broad range. In other words, if they had had a program or a unit for persons, female

offenders, what have you, we would have looked at that more prominently. I, quite frankly, wasn't even quite aware, you know, where she even was housed; and I still don't know quite -- well, I didn't even ask the question.

Q. So, as part of the evaluation, did you ever -- was she ever in any of the groups that --

A. No.

Q. -- that you met with?

A. No.

Q. So have you ever met --

A. No.

Q. -- with her?

A. No.

Q. Or have you -- And in your informal time on the MSOP grounds, did you ever interact with her at all?

A. No.

Q. Do you --

A. I still don't know where she's housed, or was housed.

Q. And what other programs are you aware of?
A. Well, the one I was most familiar with was Washington; and they -- that person was housed initially at the women's correctional facility.
Q. And was that also just one individual or --
A. One individual.
Q. And is that the only other program you know of that?
A. That's the only one that I've actively been involved with, yeah.
Q. And so it sounds like, is it fair to say you were surprised to learn that this -- this individual, this woman, was living among men at MSOP?
A. Yes.
Q. Do you think it's best practices for a women to live amongst male patients in a sex offender program?
A. No.

Q. Do you -- Do you agree with that as a representation of the phase 1 of the MSOP treatment?

A. Right. I think, with complying with facility rules, there's a therapeutic purpose in that regards. In other words, do they demonstrate behavioral self-management such that they can comply in inappropriate ways and in various stations. So that is the treatment purpose, so that they then can move on to other levels and more sophisticated self-regulation. But I think the facility rules piece, I think, is more than just compliance per se; it has a very specific treatment component to it.

Q. Well, maybe -- Can you expand on what the treatment component is?

A. Well, again, it really has to do with being able to show attentiveness so they can get the most benefit out of the treatment experience: In other words, being able to sit in a group without becoming highly disruptive, things of that nature, so they can get full benefit.

Secondly, that they can have general compliance within a living environment -- so, again, that all the attention and focus is not on just accommodating daily frustrations; that they can move on to more broader treatment type of issues.

So it's really more what I'd call a stabilization of the person's condition, such that they can get the most benefit from going into a more sex offender specific kind of focus.

Q. And do you think it's fair to say that most people who are in the MSOP program are coming from -- likely coming from prison?

A. Yes.

Q. Do you think that, if they've spent some time, presumably -- if they spent time in prison, that they would have gained these skills to learn how to comply with a structural environment such as MSOP?

A. To some degree. To some degree, yes -- in other words, the compliance, following sort of -- follow the rules; but not necessarily the skill set to how to manage their own sense, as far as attentiveness, how to get active participation within the treatment process to get the full benefit from the experience. And that's what the focus, then, has to be for -- in many ways, it's preparation for treatment; and that you don't usually receive in an institutional setting.

Q. And just to step back: Have you been involved in any sex offender treatment programs in

prison settings?

A. Yes.

Q. In which -- which -- which prisons or, I should say, which states?

A. Well, in the state of Oregon. And I'm actively engaged in all the prison systems of Scotland and England. I'm engaged in -- Let me think. I was involved of course with Washington in their prison system, as well, before, other than just their civil commitment program.

Those are the only that I can think of on site. I mean, I've done a lot of training in states, specific to institutional treatment programming within the prisons; but as to actively engaged, going into the prisons, looking at their facilities, looking at the process, I can't think beyond what I just mentioned.

Q. So you have not had any involvement with the Minnesota --

A. Corrections?

Q. -- corrections?

A. Not, again, where I went -- I'm trying to think. Have I ever gone on site? I've had a lot of discussions with folks with their sex offender program in the correctional system through the

years, in providing information, curriculum, things of that nature. But I'm just trying to think now, have I ever been? I don't think I've actually been on the site, corrections site.

Q. Well, how -- how is MSOP different from a prison to you?

A. Well, of course, for starters, the intent of course is versus -- is different in and it's reflected in the environment. For instance, rather than just containment, safe -- safety within that containment, that it has a therapeutic focus; so the environmental aspect of it is part of the therapy process. So there's a softening -- So starting, for starters, just environmentally, there's a softening of the environment to make it more therapeutic.

Q. And how would -- How do you -- How is it softened? Can you describe the softening?

A. In a number of different ways. And, again, that's even part of our discussions in our reports. But by the very furniture that one puts someplace, is putting carpeting, having collection areas to where people can be engaged in activity. It's a -- The interaction between security staff and clients is a significant difference in the two types of settings, because a security staff have their

primary role as security, but yet there's a therapeutic component to what they're doing. And, thirdly, of course is the activity itself. The activities themselves are introduced to provide a particular treatment outcome, where, in prison, there isn't activity specific for treatment outcome. There might be diversional activities to keep peace, peace on the ranch, but it's a very different kind of intensity of focus in that regard.

Q. But as far as the -- for instance, the new unit that was constructed up at MSOP, is the overall layout of the building with the housing units and where the patients sleep, is that comparable to a prison layout?

A. Yes. If you're talking about the new complex, the 90-bed -- 96-bed units?

Q. Right.

A. Yes.

Q. And even the -- I believe there's something like 68 unit -- 68-bed units --

A. Right. Pods, yeah. Yeah, I'd say that structure is similar to prison settings.

Q. Does that -- In your opinion, does that structure inhibit the therapeutic nature of --

A. I think, again, in our reports, we

reflected our concerns, community reports, that type of architectural approach and structure can be limiting and can create barriers; and, therefore, we suggested that this is an area that needs to have attention in how to soften that issue, how to address the counter-therapeutic aspect of that kind of an environmental structure.

Q. Okay. In the next page, if you go to page 57, it talks about the type of treatment at MSOP, towards the bottom, I think it's the last paragraph, and it talks about the type of treatment.

So, "the treatment at MSOP facilities consists primarily of six hours of group therapy. Group therapy is commonly used in sex offender treatment programs. Individual therapy is provided only in special circumstances at Moose Lake. Individual therapy is available for clients in phase 3 of the program at St. Peter."

And, again, this is from 2011. Do you know, has that changed?

A. It has changed somewhat. Again, it's in the report. Because each year, I believe -- this is 2010 -- 2011, I think that it went to something like eight hours, and I think 2012 was -- or 2013 went up

to nine; so there's been a gradual continued increase in treatment hours.

Q. Do you think individual therapy would be appropriate for patients in phase 1 of treatment?

A. I think it has limited use. It would be much more of a -- it would be very focused. In general, I think, considering what the focus is of that phase, I think that it's -- it is less -- would be less called for.

Q. BY MR. GOODWIN: Well, when -- If you've been evaluating the program since 2006 and there have been leadership changes, when there's leadership changes in the program, is there generally a change to the structure of the program?

A. Yes.

Q. And do you know why that would be?

A. Well, there's -- there's a number of reasons. You get a new set of eyes looking at the issues. And, secondly, a person may come in with additional kinds of expertise that they want to introduce into the -- into the system. I mean, you know, it's hard -- You look at these programs, in particular MSOP specifically, with -- they have gone through remarkable amount of change, you know, as to structure leadership changes as well as then just

the growth. The growth process has been very significant in relation to the many programs that we see. So does that cause some disruption? Yes.

Q. Do you think that disruption has held clients back from progressing through the program?

A. I can't speak specifically, but I'd be inclined to think that it would have some impact.

Q. Okay. And if you would turn to the next page, 62, it's talking about the amount of treatment. And if I -- And, again we'll get to your report specifically in a little bit. But if I recall correctly, your evaluations have found MSOP, the amount of treatment to be within the range of best practices but at the lower end. Is that fair to say?

A. I think we made a statement, something in regards to "lower end" in one of our earlier ones, as that has moved up; that now the level of treatment services -- or treatment dosage, as such, is nine hours, I believe was the last, falls well within the mean of other civil commitment programs.

Q. Okay. And here, if you look, there's a bullet point about a third of the way down the page: "The amount of treatment delivered at MSOP facilities is lower than at any other adult inpatient treatment program in the state."

And if you -- if you go down a little further, it talks about how the Department of Corrections has a minimum of average 12 hours per week for sex offender treatment in the primary phases of treatment. And further down, it talks about Alpha Human Services, which is a program outside of the Department of Human Services, the Department of Corrections, where it provides a 20.5 hours of scheduled group therapy per week.

Does it come as a surprise to you that a program that's designed specifically for inpatient sex offender treatment offers less treatment than these other programs?

A. Not necessarily -- because, again, the 12

hours versus nine hours, the definition is what treatment is.

I do know that at MSOP they are very sensitive to the fact that treatment is treatment. In other words, there's a number of things that can be therapeutic but not necessarily would be seen as treatment hours, being looked at through sort of a legal microscope. And so I think they've always been quite sensitive about making sure that their hours meet that criteria.

Now, I don't know what the other programs -- when they say 12 hours or 14 hours, I'm really not sure. Sometimes some people look at certain recreational hours that are prescriptive in some way and they look at that as a therapeutic process. I used to do that in the programs I was involved with all the time and meet Joint Commission standards; but yet at MSOP they do not do that. If they in fact did that, as I had suggested early years on, they more than likely would be scrutinized that that's really not treatment hours; but yet it would meet accreditation standards.

So I don't know what this sort of means. All I know is that they fall well within the mean of other civil commitment programs of sex offender

specific treatment.

Do you think that's a valid criticism of the program?

A. I don't think -- I don't think it really states that more -- That question -- That issue is much more complex than what that states. I think it understates the issue. For instance, from the literature, using the risk principle, the risk-needs-responsivity model, that the -- that higher risk should have higher level of intensity of treatment. That makes sense. Then the question is: How intense should it be?

When you take a look at what does "intense" mean, and you look at, especially from the literature from what -- the "what works" literature that identified the whole risk principle came from, the Canadian system, that nine hours a week would be considered high-level intensity treatment.

So, with that said, then the question comes back to: Yeah, but what about these other programs that have more? Well, one can raise the question: Maybe they're doing more treatment than they need to or should. Because part of the risk principle is this: That if you have lower risk and

you're providing high-risk intensity, in fact it could be contraindicated.

So one could almost make the argument that it's sort of one size fits all. Now, at MSOP it is sort of one size fits all, in that they've all been identified as high-risk individuals. So I don't think -- I think it can be very misleading, what that says, from my -- from my judgment.

MR. GOODWIN: Okay. Do you want to take a

Are you -- Are you familiar with the matrix?

A. Yes.

Q. And is that -- It sounds like it's a fairly common structure for this type of treatment program?

A. Yes.

Q. BY MR. GOODWIN: Well, how about in 2011, when this was written? Do you think, in 2011, at that time, that the matrix factors were overly subjective?

A. We addressed in a number of our evaluations the need for more clarity and behavioral markers in regards to the matrix process. So when you say '11: '11 was better than '10, and '10 was better than '09; so there's been ongoing progress in that regard, but we have indicated that -- what has been an ongoing issue in giving attention to the

definition.

Q. Do you think that, or have you seen MSOP establish more objective measures for these matrix --

A. Yes.

Q. And what would be an example of --

A. Well, I can't give a specific example, other than to say that they -- they created a Likert scale for measurement -- and, again, when I was involved with the phase progression evaluation -- that gave more behavioral description to all of the various treatment targets, areas of the matrix system. So it was significantly improved from what we saw certainly back in 2009; there's been a continual improvement in that regard.

Q. And you said a Likert scale. What is a Likert scale?

A. A Likert scale is a one to five and what does each -- if you give it a one or two, what does that mean behaviorally? How would you know it's a two? It isn't just -- Rather than guessing, how is it actually defined in such a way that you'd know how to give it an actual numerical score? And that definition and behavioral clarity was significantly improved over the past three years, the past three

evaluations that we looked at.

Well, first of all is the PPG, or the penile plethysmograph, is that a -- as far as you know, a valid tool to measure sexual interest?

A. It's one of the -- Yes, it's one of the tools that oftentimes is used in the battery for measuring deviant sexual arousal.

Q. Is that -- Would you characterize that as a reliable measure of deviant sexual arousal?

A. It's -- Like most of these tools, it should not be relied upon on its own; but, yeah, it's a common and important assessment tool as part of the battery of assessing deviant sexual arousal.

Q. And do you know when PPGs are administered in MSOP, as far as by -- what I mean, in the treatment progression of PPG?

A. You know, I don't know exactly, but I'm assuming that this is done from a treatment perspective; that once they get into phase 2, it's

Q. Okay. Do you know when a polygraph would be administered to an individual in the MSOP program?

A. Well, my understanding is polygraph is

first initiated when they're starting to do their disclosures of past history, past offenses -- which is, again, usually the first part of this phase 2; but, again, I can't -- I can't say specifically just when it's initiated. But the -- I knew -- I know more about the intent: The intent is to identify an accurate sexual history.

Q. Okay. And the Abel Assessment of Sexual Interest, the same, is that -- Well, first of all, what is the Abel Assessment of Sexual Interest?

A. It's what we call a visual reaction time. Instead of measuring penile reactive response to stimuli, it's -- instead, it is a visual reaction to stimuli. So as you respond to a picture, you then hit a button, and so how quickly you respond to that visual reaction is being measured. So it's a measurement of sexual interest versus just sexual arousal.

Q. Okay. And then if you'd turn over to page 79, it addresses clients with cognitive deficits. And in the section right by the alternative program, on the side there, there's a point: "MSOP's lowest functioning clients may not be able to complete the treatment program."

Do you think that's an accurate statement?

MR. IKEDA: Objection. Vague as to time.

Q. BY MR. GOODWIN: Do you think it was accurate in 2011?

A. There may have been some -- There may have been some clients that may have had difficulty with the material. And I believe we shared that in one of the reports -- I can't remember it was the 2011 report -- to make sure that, with the new curriculum that they were developing, the psychoeducational curriculum, that some of that needed the language. And, again, the MSOP was well aware of that and, in fact, were working on that. But that was one of the responses we had in our evaluation, that some of the material is still at a higher level than what might be comprehended by some of the clients.

Q. And, granted, you -- I know you haven't conducted your evaluation for the 2014 year yet; but, as far as you know, in 2013, had MSOP addressed those issues?

A. They had addressed most of those issues. They just hadn't changed the language on all of the psychoeducational modules, but -- So what that meant was we went in and looked what they were actually doing within the classroom itself. And, for the most part, what we saw was that the facilitators were adapting information. What we suggested,

again, that it needs to be more manualized so everybody is doing the same thing. But they were -- it was -- they were making reasonable accommodation, from what we observed.

Q. And, as far as you know, have -- has the treatment for people with these cognitive difficulties been manualized?

A. It hasn't been completed, but they are in the process of doing that.

Q. Well, if there's roughly 700 people in the MSOP program and, say, roughly a hundred people are in the alternative program, does that strike you as a high percentage of people with these cognitive disabilities in a program like this?

A. No. No. We generally see that -- you're talking about 10 to 15 percent, to see people fall in special needs, because keeping in mind alternative programs, a broad -- somewhat a broad

range of folks might fall into that. And so, yeah, that seems reasonable from other experience and settings I've been in.

Q. As far as you know, has there been any change to the -- to the program for alternative program clients, where they have a different yardstick per se to be measured by for completion of the program?

A. They are, but I can't say specifically

what that is; but, definitely, the threshold has been modified. As to what degree it's been modified on paper, I certainly know that when they review as to -- anytime that you have a scoring of the matrix, there's some subjectivity to the process. And all I'm saying is that, one, there's been a significant change as to the thinking about what the criteria of the threshold should be; and, number two, they're actively engaged in the program of actually redefining what the thresholds are as well.

Q. And outside of the clients who are in the alternative program, there's been some -- and it shows up in the auditor's report, about concern about clients who are not officially in the alternative program but have other cognitive or mental illness problems that are so significant that that's interrupting their ability to get through the treatment program.

Are you aware of any efforts to address how to modify the program to fit people, say, with cognitive difficulties, that don't score into the alternative program officially?

A. I can't speak specifically to what mechanisms have been implemented per se. We've had a lot of discussion in this regard, in the last

three years, within our reports. And part of that is sort of having a process by which, if a person isn't moving -- and there might be barriers to why they're moving, that may be the very issues you said -- there needs to be a mechanism in place that alerts the system that they're not moving and there are some issues that need to be addressed, and that there is a response to that, in other words, a written response as to why that person isn't making it and what accommodation should be made, especially unique to a person who's having issues with mental health or mental issue -- mental illness types of issues.

So we have talked in terms of a mechanism needs to be instituted that catches these folks and then creates a sense of accountability that we're doing something about that. And that's been, I believe, in our last two reports we've shared that, as well as in the phase progression report, I think that was also stated as a mechanism to be instituted.

Q. And, as far as you know, has such a mechanism been put in place in MSOP?

A. The last report, we did not see a formal mechanism; it's been more of an informal -- in other

words, a person moving within the team process there's a discussion: What's holding the person up, what have you. We suggested a bit more formalized approach to that process, and a more documented approach.

Q. But at this point is there any formal process to catch these people?

A. My recollection, we did not see that in the last evaluation, a formal procedural process and how that happens.

Q. Have you had any -- Are you aware of clients in the program who -- who can no longer -- who can learn no more from the MSOP treatment?

A. Again, I can't speak to specific clients; I can only look at it in looking at the alternative program. And we have suggested in the reports that

there are clients that may likely have reached maximum benefit within that experience and could receive services in a different setting, and -- and, again, a mechanism on how -- how that is done.

Certainly, MSOP, in our last meeting, a lot of discussions as to attempts to do that. I think, at the time, there was attempt to transfer and move some folks to Cambridge; and I think there was some limitations put on that, outside of the MSOP process. So there's a great deal of attention being given to that, and it's very likely that there are some folks that are -- have received a maximum benefit.

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Q. Well, so for -- Would you say that you see MSOP as coming from a correctional perspective?

A. Not a correction -- It comes from a treatment perspective; but what I'm saying, it's

more grounded in issues of -- these folks, number one, have come from a correctional setting -- versus St. Peter's, those folks came from community and mental health settings. So that -- I guess what I'm saying is that it has a correctional influence to the process by the very nature of where they came from, as well as some of the security procedures that have to be instituted that are going to draw upon correctional experience for providing security.

I mean, the intent and the focus has always been -- from what we have seen, was from a mental health perspective; but, clearly, we're dealing with clients that spend most of -- many years in correctional settings.

Q. BY MR. GOODWIN: Okay. Well, would you -- Is MSOP -- Can you maybe explain a little bit about the -- there's the -- is it the cognitive based approach and the skills based approach? Is that a

fair --

A. They're not separate. It utilizes a cognitive behavioral focus of treatment which gives particular attention to skill building. And so that's -- that is what we generally see is the primary focus in treatment programs in the field, and that's what we said in our reports is what the MSOP has been demonstrating.

Q. BY MR. GOODWIN: Currently, if there's an individual who lacks the cognitive ability to complete the program but they're kept in this MSOP facility as opposed to someplace else, is that counter-productive?

A. I think that -- that any -- anytime that

-- Boy, I got something in my throat.

Q. Yeah.

A. Anytime that a person's in a program and they're not able to move through the prescribed steps of how to progress through that process due to -- they're incapacitated in some way, whether it has to do with mental health issues or intellectual deficit, that issue needs to be addressed as to what is another alternative for that individual, yes.

Q. And, to your knowledge, has -- has MSOP done that?

A. I can't speak to specific cases. I can only specifically speak to one. What we have suggested in our evaluations is that they need to look at alternative options. And we've also suggested that, if a person gets to that state, there needs to be an evaluation specific to what are the barriers; again, those barriers be addressed within the setting; and, if not, what are some alternatives to that; and that, in our discussions with the team, that they have made specific -- given specific attention and effort to that.

Now, as to the actual results of all of that, I can't speak or give any specifics to that; but that has been something that clearly has been

given specific attention by MSOP and us as evaluators.

Q. So these issues that -- These recommendations, as far as you know, has MSOP implemented any of these recommendations that you've -- or your -- the evaluators have suggested?

A. They've -- Yeah, they've done a number of things. Again, they've tried to find some alternative placement. They have made -- tried to make adjustments within the system, for instance, when you said "cognitive," some of the cognitive therapies, and addressing those issues in ways that are appropriate for persons at this level of functioning. So they have made significant change of accommodation of the actual treatment materials and the treatment focus, and they are looking and have been looking at alternative placements.

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Q. Okay. Do you -- As far as you know, does MSOP provide individualized treatment plans for each patient in the MSOP program?

A. Yes.

Q. Okay. And down towards the bottom of page 83, there's the bullet point that says: "MSOP has had difficulty identifying and meeting the needs of some clients with low IQs, learning disabilities, memory problems, and certain less obvious cognitive problems."

And starting with 2011, do you think that was a fair criticism in 2011?

A. Well, I guess, in terms of what -- you know, what some clients -- There's going to be some clients, because they're in the process of trying to modify the cycle educational modules for these individuals, as I had mentioned before, how to identify thresholds to where the person might be able to go to a less restrictive setting and reach maximum benefit. So we look at sort of the themes and the trends, and the trends were -- has been very positive in the efforts in reducing barriers to that happening. Is there some -- And 2011 still had some difficulty meeting it? It would seem to me that would be accurate.

Q. Is that accurate still today?

A. As of our last report two years ago, I don't believe we make -- made a statement as specific to that, other than, again, that there

needs to be continued attention to make sure that the readability of the material, things of that nature, is a continual focus.

But, you know, this is not unique to programs like this, in that persons with intellectual disabilities, until it becomes much more manualized, there's always going to be sort of a clinical drift because you're dealing with folks that have such a wide assortment of disorders. And so it isn't like there's an easy way to do that. Every program I've ever worked in, it's almost like an ongoing project to make sure that you're adapting the program to the unique needs of an individual who might be mentally ill, intellectually deficit, a brain trauma. You know, we're dealing with some 250 different syndromes when we talk about special needs clients.

So it's an ongoing process. Our evaluations has been that -- that we shared some of the areas to give continued attention to, and that there has been significant movement and progress in that area.

Q. And if you look at the last sentence in the -- on the page there: "Failing to identify and meet the special needs of clients at MSOP facilities

can result in a client not participating in treatment," and it goes on from there.

But do you think -- Well, first of all, do you think that's accurate, that if there's a person who can't participate in treatment, that would affect their motivation to continue treatment?

A. Yes.

Q. And this is an issue that's -- that's come up in your reports and elsewhere, that motivation is a concern at MSOP, given the fact that nobody has been successfully released from the program.

Do you -- How is MSOP addressing those issues, that you've seen?

A. Well, I think they've been giving it a lot of particular attention, and part of it is just from a therapeutic perspective. They did a great deal of training in the areas of motivational interviewing itself, which is a motivational process, and so they -- they did a lot of training in regards to that. They also, I believe, have tried to, again, create more what I'd call therapeutic environments to where -- which is also a motivating process, as to -- They have talked in terms of -- The movement has changed. There has been more movement between phases, which is also motivating, and so...

They also have the issue of -- They created, I believe, some kind of a committee that had to do with -- that clients are actively engaged in and doing -- looking at environmental effects and to try to make the environment a more motivational experience. And so I think they're doing quite a range of different things.

I do know that they've given really a lot of attention, in relation to when I see other programs, to this issue, primarily because of the very problems that they're fully aware of as well, is that, when you don't have movement, it has damaging effects on motivation of clients.

Q. Okay. And the next paragraph there, it's talking about the issue of motivation and it starts off with: "Suspicions that clients are malingering can also affect whether clients' special needs are identified in a timely way. Treatment is hard for many clients, and clinicians sometimes suspect that a client is unwilling to put in the hard work required, rather than being unable to do the work."

From what you've seen in the program, have you seen -- do you think that's an accurate statement as it was in 2011?

A. Well, I guess I look at the various parts

of that. "Suspicion the clients are malingering can also affect whether the clients' special needs are identified in a timely way." That can happen, yes.

"Treatment is hard for many clients and clinicians sometimes suspect that a client is unwilling to put in the hard work." That can -- That happens, I'm sure; but I did not see it as a trend or an overarching issue, or we would have identified -- we would have stated that as such in our reports. Because that's the kind of thing we look for, is overarching attitudes that are getting in the way of progress.

So are there incidents of that? I would expect so. And does it seem to be a prominent feature over what has happened in the program? I did not see that.

Q. And as part of your evaluation, how would -- how would you identify that? Through...

A. The way we try to collect information, because we're looking at components of the program and that sort of -- just saying: Is it happening? What is the quality of it happening?

The other thing we want to look at is sort of the attitudes and the culture. And the way in which we do that is, again, to meet with a broad

range of folks under different experiences, talking with them in groups, then debriefing with them after they've done treatment activities, to kind of get a feel as to how they think about their work, how they think about the clients that they're working with.

And so we're very engaged in trying to look at sort of trends that could be getting in the way of creating a culture that is nonmotivating.

Q. Okay. And the second to last paragraph, about halfway through, starts with, on the right side of the paragraph: "Failure to address learning disabilities or academic deficits can hold clients back."

Do you think that's an accurate statement?

A. Yes. Failure to address can hold a client back, yes.

Q. And have you seen -- How has MSOP addressed that issue?

A. Well, obviously, initial testing, for starters, as to what is the intellectual functioning. Also, to a large degree, MSOP has somewhat had the benefit, since they started with sort of the SNS program, a lot of folks with experience and working with persons with intellectual disabilities. That sort of expertise

has then sort of been brought to bear within the MSOP program.

So I would suggest that more staff -- Likely what we saw is a lot -- staff seemed to have a sensitivity to this issue and to identify when people are running into intellectual deficit blocks. So, to a large degree, the program has quite a bit of sophistication in this regard. And how that has happened? Well, part of it is training, I suppose; but they also have a very engaged alternative program, that's directed there by Haley Fox, who is trained in this area, specifically, working with these kinds of issues. So I think that has really impacted the entire system. There's definitely a sensitivity to these types of barriers when they're being presented.

Q. And are you aware of -- Maybe on the sensitivity to these issues, are you aware of actions MSOP has taken to address them specifically?

A. Again, I don't -- can't -- I don't have examples of particular cases. I just know that -- that what we observed was where they would make specific adaptations to various approaches, to various material that was provided to the clients. So, in that sense, clearly, someone was making

decisions that modifications needed to be made and were being made; so I saw -- clearly saw examples of that happening.

Q. And assuming there's been movement within the program, though, to your understanding, none of these people have been able to actually exit the program; is that accurate?

A. No one has left the program, no.

Q. BY MR. GOODWIN: Well, do you know how someone ends up in the alternative program or not?

A. I know one -- one route that a person -- If a person is having difficulties with material,

and it could be because of intellectual deficit, things of that nature, that are getting in the way, there's team meetings of which the team then will raise it to another level of review and then they assess the situation at the time.

So there are a lot of systems in terms of the treatment review and ways in which that can be introduced for discussion as to whether the person should be transferred, as to what the actual criteria, the decision is. In many cases like this, it requires more sophistication of a process than it does a strict criteria, because a strict criteria could miss out on -- again, there's so many nuances to this kind of problem area, that you have to have a good system versus specific criteria.

Q. BY MR. GOODWIN: But as far as you've seen, does MSOP have an adequate system to --

A. I did not see anything that raised alarms as to deficiency. There was a system in place; it seemed to be working.

Now, we have not, obviously, gone in to take a look at all cases as to whether certain people have been denied or if there's persons being missed. That would take a much more intense review.

Q. Is other programs you look at, is that standard to wait until later phases to begin reintegration, or is there more of a range on them?

A. No. It's usually at some phase towards

the end of treatment.

(Exhibit 3 marked.)

Q. BY MR. GOODWIN: Okay. I'd like to go to this, I believe it's Exhibit 3, the 2011 annual performance report.

Do you recognize this document?

A. No.

Q. Okay. Well, if you'd turn to page 35, at the heading it's appendix 1.

A. Okay.

Q. And do you recognize this portion of the document that I --

A. Yes. Yes.

Q. And so it lists you, Robert McGrath, and William Murphy as the site visitors for the report; is that correct?

A. Yes.

Q. And so you -- It also lists the date of the visits as December 12th to 16th, 2011. Is that --

A. Yes.

Q. And as far as process groups, is there -- is it preferable to have process groups versus individual therapy? Or do you know why -- I mean, I'll just leave it at that.

Why does MSOP, as you understand it, use group therapy as opposed to individual therapy?

A. Well, there's -- again, there's a number

of reasons. What we see generally in the field is that we're going to see group process used, and that, by having a group dynamic, that people can also learn from each other in that process, as well as it increases accountability in the process because there's other people that give feedback, people that are also going through sort of that same treatment change process.

So group therapy, in and of itself, can be a very powerful tool in the change process. So you're generally going to see -- You're always going to see group process, or group therapy, as part of the delivery system, working with sexual offenders.

Q. And is -- In the programs, other the programs you look at, is individual therapy typically a part of that?

A. Sometimes, but not always. It varies. It also varies with individuals. For instance, you oftentimes might see more individual therapy provided for persons who have special needs issues. You'll see sometimes more individual work done with folks that are in alternative special needs programs.

Q. And, currently, does -- as far as you know, does MSOP offer that type of individual

therapy for people in the alternative program?
A. Yes.
Q. And does it generally offer that type of therapy to people in the conventional program as well?
A. Well, it somewhat, again, varies. In the conventional program phase 3, it does; and in phase 2 at St. Peter's, it does. It generally does not in phase 2 in Moose Lake. It doesn't mean that there aren't some options or opportunity for that; but, generally speaking, individual therapy is not utilized in phase 2, Moose Lake.
Q. Now, I know there's some -- My understanding is there's some patients who are in phase 2 at Moose Lake and some people who are in phase 2 at St. Peter.
A. Yes.
Q. Is that your understanding as well?
A. Yes.
Q. Is it different? Is the treatment different if you're in the phase 2 if you're at Moose Lake versus St. Peter?
A. I can only speak, again, sort of to our comments, is that there is some difference in programming between the two; and that was one of the

issues we raised, that there needs to be more of consolidation of consistency in that regard. And one of those inconsistencies was phase 2 at Moose Lake had -- did not have individual counseling, and St. Peter's did.

Q. And do you know if that issue's been resolved? Is there individual counseling available at both facilities now?

A. I don't -- It wasn't as of the last report, which would have been December 2013.

that new program materials developed are appropriate for clients with special needs, or develop parallel materials."

A. Yes.

Q. And at the time you wrote this, since

then, has that happened?

A. There's been progress made, but it still has not been completed, especially with the change of all of the manualizing of all the psychoeducational modules hadn't been completed yet.

Q. So then, as this process is occurring, is it -- is it possible that there are people who are not getting treatment that they can comprehend?

A. No, I can't say that; because, as I said before, even though it's maybe not manualized, it is -- it's not -- we questioned what the consistency might be, since they are adapting those issues as they go on. So the facilitators will adapt to particular needs of the client at the time.

So we did see they're adapting. Now, the question is: Is it consistent across the board for all folks, since we don't have a manualized system to look at? So it raised a question, but we -- I can't answer the question as to whether there were no adaptations made.

Q. And if you'd skip down under the heading 5, "program sequence," the last full paragraph there. Again, this issue of: "We are concerned about the high number of clients in phase 1 of the program and small number of clients in phase 3 of the program."

Is -- In 2013, is that still a valid concern?

A. Yes. We've presented it as a valid concern, I believe, in all of our reports since 2006.

So taking that first part about having the program ensure that about 80 percent of the focus of the treatment manual is on dynamic risk factors: Do you know if that is the case in the current program manual?

A. I don't think we spoke specifically to that; because, at this point in time, again, in 2011, it was still draft form. And that -- The reason I believe we did not address that is that we

felt that it was addressing the focus for being empirically supported dynamic risk factors, that piece of it.

That's the part of that sentence you're talking about; right?

Q. Right, that first part.

A. All right.

Q. And so if 80 percent of the manual is focused on those dynamic risk factors, then what would the other remaining portion of the manual consist of?

A. Well, again, it can have to do with areas and issues that may have to do with motivational aspects of programming but not necessarily are grounded in empirical evidence as such.

Again, this is a new area. This is an area where there's a lot of -- some practice that is done that seems to be in the right direction, but cannot be supported with -- empirically grounded at this point. So we did not address that, because the theory manual did -- the treatment manual did highlight that more specifically than here in 2011 from this report. And, again, I'm speaking now to the first part of that sentence.

Q. Sure. And then moving on to the second

part of that sentence, that about "50 percent of the client treatment time is devoted to skill practice."

So that was one of the recommendations of the group?

A. I think we've stated in, I don't know, maybe the last three or four reports, that it falls less than that. And I believe, in the last report, we said a similar statement. There's been improvement, but it still does not meet that threshold that we had suggested. I think -- I think we also state that some inconsistency in some places and situations they were, and others they were not, but it wasn't consistent.

Q. And why is that the target, 50 percent of the time spent on skills practice?

A. Well, again, we're -- we're just drawing from the general literature, the general literature and the specific literature that has come out, again, the criminology work. And that was, again, stating sort of the preface of these reports, of the "what works" literature that's come primarily out of Canada, institutional treatment programming.

Q. And the "what works" programming, is that the risk responsivity --

A. Yes.

Q. -- model?
A. Yes. Yeah, the Andrews Bonta.
Q. And that's -- Is that standard modeled for this type of treatment?
A. For institutional programming, yes.
Q. Are you aware of -- Are any of the other programs that you evaluate or have evaluated, do they use a different model?
A. No. For the most part, the risk/needs response activity is pretty much standard expectation within programming. That's the most recent literature we have of research, anyway, specific to what are critical elements in a change process when working with offender populations.
Q. And in the next paragraph, it's talking about the structure of the treatment and the hours spent. And the conclusion there: "Consequently, we recommend that the program increase the number of treatment hours devoted to delivering services according to the forthcoming structured skill base psychoeducational model" -- "modules and increase the number of group process hours" -- "process group hours."
As far as you know, has that occurred?
A. I think what we -- Yeah, just so I can be

clear: You're talking about the last part of that where we said, "We recommend that the program increase the number of treatment hours devoted to delivering services to the forthcoming structured skill psychoeducational module and decrease the number of process group hours." Is that what you --

Q. Right.

A. Yes.

Q. And so has that happened?

A. Yes.

Do you -- Is MSOP, in your opinion, providing enough opportunities for community outings?

A. I'm not quite sure when you say "enough." It's increased. It's increased from this particular report, 2011 to 2013. It seems to be appropriate, you know, the pace of involvement in the community

of the -- Again, we're talking about this relatively small program. But we didn't see anything out of the ordinary of concern in that -- in that respect, and that's why we didn't identify that as problematic in our recent report in 2013.

Q. So for other programs that you evaluate, or have evaluated, is there -- are there programs that initiate things like community outings and more interaction with society earlier on in the program?

A. I can't -- I mean, I can't speak specifically anymore, I mean, because some of the programs have been programs only that I saw a number of years ago.

But, for the most part, this is generally what you'll see when a person gets to this point, is when you start the transition process to the community. So this is -- this does not -- this is not out of what you would expect in looking at civil commitment programs.

Q. And my understanding is that, in the past, and this is -- this is some years ago, maybe before you were associated or affiliated with the program, but there was more, particularly on the St. Peter campus, patients even in phase 2 had more opportunities to go off campus and interact with

people outside a secure perimeter.

Is that something you see as beneficial to treatment?

A. Integration in the community is beneficial, yes.

Q. And this has become an issue recently about some of these people who go from spending a fairly lengthy time in prison and then a fairly lengthy time in the MSOP program, so that they've -- you know, some people have spent a good portion of their life within some sort of institution.

A. Right.

Q. Would it be beneficial to help people reintegrate into life after MSOP by initiating some of these opportunities earlier?

A. It may.

Q. Do you see a possible negative therapeutic impact on having these opportunities early in the program, like I said, in phase 2 at one time, and then have those opportunities retracted across the board for people in phase 2?

A. In other words, just so I'm clear, you're saying: Was it detrimental to them to have some of these privileges and then have them removed? I think that's always a disruptive kind of thing when

you have certain freedoms and opportunities and then those are changed.

Q. BY MR. GOODWIN: Well, currently -- we'll start there -- do you see a problem with a hostility between staff and clients at the MSOP?

A. No. Well, I take that back.

Certainly, there's some hostility towards the program by clients, because of the very issues that we're talking about. But, no, I don't generally see a hostility between -- on a personal level, between staff and clients.

Q. When you've had meetings with clients as part of the annual evaluations, has this been an

issue that you recall coming up?

A. Not that specifically. Issues were different.

Q. What -- When you have had these meetings, what were some of the issues that did come up, that struck you as concerns from the clients?

A. Well, they sort of ranged. One was, you know, why can't we have the number of things we used to have? And so it had to do with just general privileges within an institutional setting. So that's one.

And the other thing is just sort of the overarching concern, and that is: Nobody gets out of this place. And that's, I think, what we've shared in all the reports, that it's -- this is the predominant issue of everyone, is that, "Why do anything? Nothing happens."

Q. And that actually leads into this next -- the last paragraph starting on that page: "Although the program has made strides in preparing clients for discharge, none have yet been discharged. This is partly due to the slow movement through the program and the multiple legislatively required steps for discharge in Minnesota. The lack of anyone getting out can be demoralizing to clients

and staff, and, in the long-term, will likely increase security concerns."

Do you still agree with that statement?

A. Yes.

Q. And what -- when you said "this can increase security concerns," what do you mean by that?

A. Well, when people become hopeless in a process, they start reacting within the environment they're in; and so -- because of frustration and anger and what have you. And so it's pretty common, when people don't have a sense of movement or change or opportunity, that they start acting that frustration out.

Q. Okay. And if you'd turn to page 9 of eleven, there's the service documentation is the topic and it's talking about the documentation in the client records. And in here, the final sentence: "Several of the records of the treatment group progress reviews were limited in content regarding examples that indicated progress by the client."

Is that -- Is that still a concern, the amount of documentation of client progress at MSOP?

A. In one area, there's -- The one area that's part of this -- that comment is -- has improved, and that is to -- that the progress itself, how it's documented mainly, because the matrixes are clearer, the behavioral descriptions are clearer, and therefore the documentation reflects that.

What is not still reflected, and is in our 2013 as well as, I think, our 2012 report, is -- what isn't documented as clearly as we would suggest as to what those barriers are, why they're not

moving and what is being done about it.

Q. Generally, my understanding, and correct me if I'm wrong, is that, you know, if there's an incident where someone's acting out of line, they -- there's a series of major/minor redirection. These are things that go in someone's file to show that they're falling -- I think it's "behavioral control," is the term is used.

Are you aware of any system in MSOP -- So I guess the point I'm making is: These generally reflect negative behavior; is that fair to say?

A. Yes.

Q. Are you familiar with any sort of system in MSOP that reflects achievements, or sort of a counter to that, where you're saying, "Hey, this

person's" -- "You get a gold star," something to that effect?

A. Yeah --

MR. GOODWIN: Your microphone just fell.

THE VIDEOGRAPHER: You lost your mike. Thank you, sir.

THE WITNESS: Not specific, you know, like a report that's a standalone; but it is -- it certainly is embedded within the documentation of progress reviews, and those are reviewed during their quarterly meetings.

Q. BY MR. GOODWIN: Well, is it a concern that you have this full system for recognizing and correcting negative behavior, but the positive behavior, it sounds like, is primarily recognized in the treatment records; and then if there's a concurrent lack of records in the treatment, is it -- is there a concern that the negative issues are more identifiable than -- than any positive behavior that's been exhibited by a client?

A. It could be. And that's why -- that's why we asked questions about the BER system. It's out of those questions we asked, is why the MSOP -- and I think it was in, again, the '12 or '13 report they did a review of their BERs as to what is the impact,

who's receiving them, how frequently are they being used, what have you, so to bring greater attention to that issue.

It's also why we looked at that in the -- when we did the program on phase progression to see, are BERs part of the process that's getting in the way of people progressing? In other words, are they getting an inordinate amount of attention that is creating a problem?

So we have -- we have looked at those issues. In looking at those particular issues, there was nothing that seemed to indicate -- and that's why we did not state that, specifically to the fact that they seemed to create an inordinate barrier to the process. But it's certainly something one always has, and that's why we've highlighted it, that the program has to continue to look at that BERs don't take and get that kind of attention that could have that kind of impact. But it has been looked at and it has been addressed, and MSOP has been looking at it as to, you know, what is the general impact of BERs.

So that's as far as we've gone with reviewing that up to this point. Again, it's been only a recent move to where we've been looking at it

in the past two to three years.

Q. Maybe to step back for some perspective: Is -- Are the recommendations you make, is there any obligation for MSOP to follow, or are these advisory?

A. Totally advisory.

Q. Are you aware of any agency or entity outside of MSOP, that provides direction to MSOP, that they're compelled to respond to?

A. None other than -- and, again, I don't know the specifics -- there is some licensure requirements as an institutional setting; and what the specifics of that is, I'm not sure. Of course this -- these reports also become public record; so, again, how they're utilized within, you know, other parts of the agencies, I can't speak to.

Q. Okay. Well, just to turn towards the last -- or page 10 of eleven here. Actually, sorry, it starts off on the bottom of page 9 of eleven.

"Over the past few years, there was a shift increasing security procedures, client restrictions, and security staff having more exclusive" -- "having a more exclusive role. During this site visit, there was a noticeable increase in discussions and actions being taken to balance

security needs with clients' treatment needs."

And, as far as you're aware, have there been any changes that have resulted from these discussions --

A. Yes.

Q. -- about --

A. Sorry.

Q. -- just about balancing security and treatment?

A. Yes.

Q. And what are some of those?

A. Again, it's hard for me to just be specific, other than I know that there's been a number of just rules, regulations, expectations that have changed, that, again, have softened -- softened the environment as to -- Also, there's been a significant change in the level of movement that people can have within the setting, going from one place to the other without being restricted or having staff escort.

So, yeah, there's been a very noticeable change in the reduction of what -- you know, of restrictions and rule policy that was not necessary, and there has been increased movement.

(Exhibit 4 marked.)

Q. BY MR. GOODWIN: Okay. Are you familiar with this document?

A. Yeah, generally.

Q. And if you would -- Now, this is the full annual report.

A. Right.

Q. And if you'd turn to page 35, this is the appendix. Again, it looks like this was authored by you, Robert McGrath, and William Murphy?

A. Yes.

Q. And the date of report was -- was January 7th, 2014; is that --

A. Yes.

Q. -- your -- accurate?

So prior to -- Do you submit this report to -- Does it go to -- Who does it go to when you're done with it?

A. We send this report to the -- to the clinical director and executive director.

Q. And prior to them getting the report, do they have input on the -- on the report as you're drafting it?

A. They have input, yes.

Q. Do they review drafts of it?

A. Well, how the process works is this, is that once we have done the report -- We want to make sure that the report reflects accurately. The people want basic things, basic -- the names of individuals, titles, dates, sometimes the particular numbers that we have taken from them and that we want to make clear: Is that what the number is? So it's those types of edits that we ask for. What we don't do is solicit or respond to changes of any kind of content of the reports. That's the expectation we have, as well as they well understand.

And so, yes, they do see the draft; and, yes, they can give input as to edits, which usually

are quite infrequent; but they do review it prior to us completing it.

Q. So for this 2013 report, do you recall if -- So that would be Jannine Hébert and Nancy Johnston who would review it?

A. Yes.

Q. Do you -- Do you recall if either one of them had any edits to the document?

A. You know, I can't remember for sure. That would have to be a question, I think, shared with -- because I think the final review edit of this was with Bob McGrath, Robert McGrath, but it would be very -- it would have been of very small edits; otherwise, we would have had a meeting about that, in any way -- which, again, I -- we've never come across in the seven years; but it would have to be very, again, "typo" type of edits.

Q. Okay. And at the bottom of the first page here, under the summary of findings, the last full paragraph: "MSOP, however, is responsible for providing timely and effective treatment designed to help clients reduce their risk to sexually reoffend and reintegrate back into the community."

Is that -- Do you agree with that statement still?

A. Yes.
Q. Do you think that MSOP is providing effective treatment to satisfy that?
A. Yes.
Q. And how -- how is that possible if nobody's actually been reintegrated?
A. Well, because treatment and movement is two different things that have different variables involved. And, as we've shared in other reports, there's a number of things that MSOP could do that we feel could address this issue of slow movement, as well as we've addressed the issue that there's also external issues that are affecting the movement.

So the components of the treatment, the model of the treatment, in most part, is intact as a program that has capacity to move people; but then there's these barriers as to why the movement isn't happening. So I'm separating the treatment from progress.

Q. So for some of these things where it's been recurring issues, you know, that have been raised periodically and regularly in the annual evaluation reports you've written, is: After having done this for a number of years, is MSOP responsive

to these reports?

A. They have been.

Q. And in what ways?

A. Well, I'm saying, if you take a look at all of the different things we recommend, has there been any progress in those areas? Or in some of those areas we've made the suggestion but no attention was either drawn to it or any change made? That would be pretty rare. In fact, it's hard for me, because we always go back to the very things we made suggestions and recommendations about, to see if something's happened.

Now, one could raise the issue: Is it happening fast enough? That's another -- it would be a separate issue. But they have been very responsive to all of our recommendations, and I can't think or point to a situation to where we made a recommendation, that they didn't give some additional attention to on our follow-up from between that and the next follow-up evaluation.

Q. Well, to get back to the point you just made: Do you think the changes are happening fast enough?

A. No.

Q. If -- What do you think is the most

important change that you would like to see, that is not happening fast enough?

A. You're talking about within MSOP?

Q. Right.

A. Within MSOP, I think a mechanism or a system to identify barriers of progress so that there can be a more specific and timely response to that. And we've recommended that in our last two reports and, I believe, also in a phase progression evaluation that we did last year in February.

Q. Well, given that the growth at Moose Lake and the chronic problems with getting full employment there, do you think the combination of growing a client base and a limited pool of staff to fill the positions there has compromised the treatment at Moose Lake?

A. I think it's had an impact, yes. And we stated that in our reports, that we feel that that may be limiting, because -- I think we shared in one report how some of the comments of clients as well as staff shared that it's difficult to work through some of the issues because the group sizes were larger and what have you, because, again, of lack of staffing. So it seems totally reasonable that -- that it would be part of the problem, yes.

Q. And so that impact, is that a negative

impact on the treatment program?

A. Yeah. Not having adequate staff to deliver the services is.

Q. And are you concerned that that is holding back patient progress through the program?

A. Can't speak to it specifically, point to a causal relationship; but I think that it's another issue or a barrier that one has to overcome, that can impact progress.

Q. BY MR. GOODWIN: Well, looking at the documents reviewed and the individuals contacted about your analysis of the program, outside of the clients that you've interviewed, is it -- is it fair to say that the source of your information comes from MSOP?

A. Yes.

Q. Okay. And then under that same "procedures" section, towards the bottom, it's talking about -- there's -- three lines up from the bottom: "Attended the following treatment groups" -- I guess it's four lines up. It says: "No treatment or psychoeducational groups were held at St. Peter during the visit, as it was a modified programming week and these groups were not held."

Do you see that at the bottom of the -- page 36?

A. Bottom of page 36?

Q. Just -- Just the point about there was no program because it was a modified programming week at St. Peter.

A. Right. Right. Okay.

Q. What is a modified programming week?

A. What it means is, it's actually something that we had -- I'm not sure if we had put it in a report, but we had discussions about what to do to allow people to have breaks in between various psychoeducational programming; that the intensity of people being in programming nonstop, not having breaks, can be problematic. It also gives an opportunity by having breaks so people can do paperwork, what have you, to catch up, rethink as to what they want to do next, but at the same time to not have as sort of a time-out -- because these folks are there and they need to have continued attention to their needs, therefore to develop what we call modified programming.

So that's what this is: Instead of the right -- the tradition -- the typical training that we have, they have these modified programming

periods of time, relatively brief periods of time, to where it's still providing a treatment focus but it's just doing it in a different kind of way.

Q. And so how -- If you were a patient in the MSOP program during a modified programming week, how -- how would it look different than a regular programming week?

A. It can vary in a bunch of different ways. Some of the things that are done is doing things as a group, full group, larger group activities, group activities that have particular attention to anywhere from motivational kinds of focus to enhancing the treatment culture, to actually providing specific kind of information, or having served show-and-tells so people are sharing information from the things they've learned from the previous period of time.

So there's a lot of different ways you can do modified programming. I know they've done it -- done it in a number of different ways. We've sat in on some of that programming to see if it's actually grounded and, from a therapeutic perspective, providing a service. And we feel that it is. But that's the value of it: It's trying provide a break for people from the routine, as well as opportunity

for people to sort of refuel until they go into the next segment.

Q. And as part of your evaluation of the

program, do you attend or do you go to all the units? By that, I mean there's -- there's the conventional treatment units and then there's the alternative units; but then there's also the young adult unit, there's the NOVA unit for high mental illness people, and the -- I think it's beta unit for geriatric and, I think, physically disabled people.

Is that -- Is that part of your --

A. Yes.

Q. -- review?

A. We try to -- We go to all the different settings. As to how much time or what we do in those settings kind of depends from what we've seen from the year before to see if we need to follow up our concern in particular areas we want to visit.

Q. And, also, in talking between these facilities, I also want to make note: You said you paid particular attention to omega units at Moose Lake. And omega units, I think, are described as behavioral therapy units where -- Maybe, can you describe what "omega unit" means to you?

A. Well, yeah. This is, again, dealing with persons that are highly disruptive to the environment and which may be generated either from just reaction to not wanting to comply with issues, to persons who are having other types of significant health or mental health issues. And so omega units, then, is a place to provide sort of a time-out for the individual, as well as focused support and treatment to get them stabilized so they can go back into the -- back to their parent units.

Q. And so why did -- why did that require particular attention, in your mind?

A. This is an area where I maybe provide additional attention to; because working with special needs populations, these are the folks that oftentimes are most vulnerable, in vulnerable

situations; they're in more isolated type of situations. So as to what is happening in those types of settings, it is usually something that I think we're quite sensitive about. We're sensitive to the fact that persons who are highly disruptive might end up in sort of dead-end situations or what we might call a back-ward situation. So we're -- we're -- we put a great deal of attention to make sure that people don't fall through the cracks in that regard.

Q. And since you've been analyzing or reviewing the MSOP program over the years, have you seen a change in how the omega unit is handled?

A. Actually, it's very -- they do an impressive job. They really -- From what I've seen in many places, they -- part of it is because they've got some very good people working in those settings, the people that are in charge of those particular units.

The other thing is we had asked them to put together sort of a protocol procedure as to how you evaluate as to when they get there, as well as to get them back and get people back in a timely way and to reintegrate them effectively to the parent units again; and they responded to all of our

recommendations.

And so, yes. But that's why we keep attention to that area; it's what we call a high-risk area for neglect.

Q. And as you've been looking at the MSOP program over the years, have you seen it -- have there been incidents that have raised concern about neglect in the omega unit?

A. There hasn't been. The only issue I think we've raised in any report was from 2011, I think, to '12 -- or was it '12 to '13 -- that they didn't have as much staffing, so they couldn't do as much individualized counseling as they had done before. We were concerned about that; but, at the same time, because of the very skilled staff they have in those units, we've saw that, again, adequate and appropriate treatment was still being provided, but our concern was that -- to not continue in a setting of understaffing in those; and, again, it's stated in one of the last two reports, I know.

Q. And for those omega units, are they individual units as opposed to are they -- How many people are in any given omega cell?

A. I can't say for certain. They are separate, they are separate structures. They're all

within the same pod area, but they are separate. I'm trying to think. I think the most restrictive area maybe has about four or five living quarters.

Q. But that in each living unit -- That's just for one person; right? They're --

A. In the area that is the most restrictive, they have a place where a person can be fully isolated, as well as another area where they may have three or four persons. So I can't remember the exact number of beds, but they have the full continuum of what we'd call safety precautions that they can -- they can introduce, from a person being totally removed from other individuals, to where they're also in highly supervised small environment, small population units.

Q. Well, I guess the question I'm getting at is: In general, most patients in the MSOP program are double bunked and have a roommate. But the omega unit, as I understand it, are those people double bunked in omega units, or are they --

A. No.

Q. Do they have their own -- They don't.

And is there -- What is the time line? Is there a set time line for how long a person is in omega, as far as you've seen?

A. Again, I can't speak. I'm sort of guessing from memory, but there is some kind of protocol review. They're looking usually within, you know, days, weeks; and certainly 30 days is sort of what would be sort of outer limit. There's some people who might be there longer; but, no, they're very conscious about quick movement. And there has been continued active recycling, moving people through those units; so they're not -- clients are

Q. Okay. And for the next point, for responsivity, the second sentence there: "Programs should consider responsivity issues such as clients' motivation, intelligence, psychopathy, mental illness, and cultural issues."

Do you think that MSOP adequately does that?

A. Yes.

Q. Sure. In relation to the alternative program, has the MSOP adequately adjusted the program to present it in a way that an individual in the alternative program can understand it and complete the program?

A. I guess I can't say it as an absolute. There's been continued improvement in that -- in that regard.

Q. Well, do you -- do you see the program, as it's structured now, as a -- as a barrier to someone who was -- who might be in the alternative program with intellectual disabilities?

A. Are we talking now specifically to the materials as to the responsivity issue itself?

Q. Yes.

A. I don't see it as significant, a significant barrier to what could be getting in the way of movement.

Q. Well, if it's -- if the program -- if the program, as it's structured and delivered, is not a barrier, what would be a barrier to movement within the alternative program?

MR. IKEDA: Object to the form. Vague.

Speculative.

Q. BY MR. GOODWIN: You can answer.

A. Well, I can only say, specific as to the barriers to movement, again, are articulated in the progress evaluation report that -- that I support; and those recommendations were very specific to phase progression and what we saw as the barriers to those. Again, I -- we can review those, but I'd be guessing to go from memory what we stated; but we identified rather specifically what we saw as the -- what was inhibiting the progress of clients.

Q. And the next sentence is: "The program also needs to ensure that factors considered for program movement are related to risk to reoffend."

Is -- Is that a concern, that there are factors that are considered, that aren't related to risk to re --

A. Is this --

Q. Sorry. The last sentence of page 39.

A. Okay. So what is the question, then, with 39?

Q. So the sentence says: "The program also needs to ensure that factors considered for program movement are related to risk to reoffend."

By the fact that you and your group raised this issue, is that a concern that there are factors that are being considered, that aren't related to

risk to reoffend?

A. It's a concern that maybe.

Q. And so is there a difference in how you approach the treatment model in a facility like MSOP, as opposed to something that is explicitly a correctional facility?

A. Not in terms of working with the theoretical treatment model that you would use the delivery of services to provide best practice. It should look the same.

Q. Okay. And if you move down the last paragraph of that section: "Our review of treatment records, staff interviews, and group observations at both sites indicated that use of skill, teaching, and practice in core and psychoeducation groups was very infrequent."

Is -- Is that an accurate observation?

A. Yes.

Q. And is that a concern?

A. Yes.

Q. Okay. And then for the program monitoring and evaluation, the third paragraph there: "In our last report, we recommended that the program consider whether the risk management committee should focus on reviewing progress from phase 3 to CPS rather than from phase 2 to phase 3."

Why did you make that recommendation?

A. We made that recommendation, first of all, not based on that we could see that it was creating a problem of movement. We raised the issue because of our concern that anytime you raise another level of review, that that can create just another inherent boundary to movement. And so we cautioned as to why you want to increase -- have another review process, because of the potential that it could create.

Q. And the last paragraph there, this talks about the concern about people not moving through different phases in a timely fashion.

Do you know if MSOP has -- has responded to this concern raised here?

A. Which particular concern?

Q. So it's -- So starting with the first sentence there: "Although there is increased movement between phases, we recommend, as we did last year, that a formal system be developed to clinically review those clients who, in a reasonable period, are failing to progress between phases."

A. They were in the process in our discussions of creating a more formal approach. Informally, they were addressing those issues now more in the quarterly meetings as to what was getting in the way. We also saw it in some documentation. But as to a consistent formal system across programming, that was not yet present.

Q. In the third paragraph from the bottom, it's talking about clinical supervisors and supervision of the clinical treatment. And partway through that paragraph, it states: "However, supervisors rarely conduct direct observation of staff leading groups."

And is that -- is that accurate as far as you know?

A. Yes.

Q. And is that a concern for you?

A. Yes.

Q. And do you know why there has been limited amount of supervision observing the actual group therapy?

A. I can share the response to that is that it is the intent and what is the expectation of the program to actually do that; but it would be kind of -- again, because of staffing shortages, which allows a person with that time. Because they're

trying to maintain with the shortage of staff to make sure they're still providing the treatment hours; and to provide -- take -- move those hours to more supervision hours means they could have a direct impact on the actual services, delivery of services. So that's why it's not happened, is what -- is what they shared with us.

Q. So, as you understand it, the reason there has been -- not been this supervision of group therapy is, is it fair to say, it's just a staffing issue with having adequate --

A. That seems to be, since there's an intent to do it and everyone's supported doing it and everyone that we've talked to, from administrative to clinical, but yet it's not happening. And it seemed -- the only thing that really seemed to make most sense was that it's the logistics.

Q. And what is the concern about not having the supervisors directly observe the group?

A. One, that you're going to get clinical drift, people doing their own thing, in a sense. There's -- It reduces the consistency of programs across programs. It also reduces the amount of feedback for facilitators to become more effective at what they're doing.

Q. Well, in that -- in that same sentence, it says: "Overall, staff were positive about the more open movement."

Did you -- Did you have any discussion with -- with clients about their perception of the AMS system?

A. There was, there was some. And aside from sometimes a person saying, you know, "I'm in a prison; they treat me like a prisoner" -- because, again, we're trying to look at themes. The theme that seemed to be more impactful was: Everyone was pleased that there was more movement.

Q. And has that -- So what has been your general view of the AMS system as to how it's affected the Moose Lake?

A. Our initial reaction to it was somewhat skeptical, and we were rather pleased to see that it seemed to actually bring about the effects that we're -- that everyone was looking for; and that was that, rather than just another way of trying to have

tight security, that in fact it was reinforcing and enhancing movement within the system. We were very skeptical whether that would take place; and we were quite pleased, quite frankly, to see, you know, that was the case. That was the first time I had experienced working with that system and good results, from first blush anyway.

Q. BY MR. GOODWIN: Okay. I just have a couple brief questions to follow up with.

First of all, about the campus arrangement for MSOP, the fact that there's a part of the

program in Moose Lake and part of the program in St. Peter's, is that a concern? I know it's come up as far as having consistent treatment from campus to campus; but, overall, the structure of the program, to have two distinct campuses like that, is that a concern for you?

A. Not necessarily. It can have as many advantages as disadvantages; so, no, I -- I think it can be done. There's a logistics, like you said, consistency; but also advantages of having another place that people can go to and...

Q. And we haven't spent much time talking about it today, but I wanted to address the group of the juvenile offenders or the young adult offender group.

In your opinion, is it proper to indefinitely civilly commit an individual who has no adult criminal record?

A. I really don't have a response to that. Usually, issues around adolescent histories and juvenile issues, I usually defer to William Murphy, who has had extensive -- extensive experience in that area over many years.

So, as evaluators, we sort of bring

certain areas of focus of expertise, and that's why the three of us work together. And this is -- that's his area of expertise.

Q. Well, given that's his area of expertise, has he ever raised concerns, in your discussions with you and the other evaluators, about -- about the fact that there are people who are civilly committed indefinitely, who have no adult convictions?

A. I can't recall, because -- On the other hand, I can't recall that we were even aware that there's individuals there that only had adolescent history.

Q. Now that you know that there are individuals who have no adult criminal convictions, that are indefinitely committed to the MSOP program, is that a concern that you plan on addressing in the next evaluation?

A. That would raise -- That would raise a concern. Again, our evaluation, we're looking at larger themes of issues, versus individual clients; but if that is part of a process, that would be an area of concern, yes.

Q. And outside of the roadblocks and the release of patients, as far as the court process and the legal steps to get out of the MSOP, in your experience, having spent some time there, do you see individuals, either people you formally or informally interviewed, where you said, "This person doesn't belong in a confined situation like this, in a high security civil commitment"?

A. No, never specifically to a client -- I mean, about a particular client. I know we're sort of looking in broader terms, our concern: Because of the way the system -- the structure is set up for movement, that persons could end up being stymied from that process. And, again, that's reflected, I think, in all our reports in that regard.

Q. BY MR. GOODWIN: Well, in your mind, is it possible to complete the MSOP program?

A. Again, as to -- and what you -- how are you defining "complete the program"?

Q. How would you define it?

A. It depends -- The program, to me, it would be the ability to move people through, into the provisional -- through the provisional discharge process. And so that -- that, to me, is the -- is what you're trying to accomplish. And as we've stated before, few people are getting to that point, and that's problematic.

Q. Is it -- As far as you know, will MSOP support a petition for full or provisional discharge from the program if a patient has not completed the

treatment program?

A. I'm not sure; because, again, it gets back to: What is completion of the program? Because we looked at situations like the folks that were going to move to Cambridge. There's -- There's some variance as to what "completion" actually means, and I think that has -- attention has been given to that.

As to whether -- what that line is now or what that criteria is, at this time, I really -- I don't have specifics, what that would be at this point.

Q. Well, looking at other programs you've evaluated, are there -- do they contain sort of a completion where you can say, "Okay. Here are the objective measures. I've" -- "I've done A, B, C, D. I've met the requirements and I'm done with this program"?

A. Yes, similar to MSOP. In other words, that's what the matrix system is: Have they met the criteria? And the matrix system is that criteria, the matrix scoring.

Q. And in -- Is it accurate to say that -- Well, let's talk about the program as it exists now.

Is it your opinion that the program operates consistent with best practices?

A. Yes.

Q. And, in fact, in your reports, you say that you evaluated the program against international

best practice standards and guidelines in the field; is that correct?

A. Yes.

Q. And, in your reports, you found that MSOP was indeed operating the program consistent with those standards and best practice and guidelines; right?

A. Yes.

Q. And that's a conclusion that the three of you reached unanimously; is that right?

A. Yes.

Q. Now, one of the things that Mr. Goodwin asked you about was accreditation by the Joint Commission.

Do you remember that area of inquiry?

A. Yes.

Q. Okay. And you had talked about how they're -- they're really -- I don't know if you said the word "impossible," but you said it was difficult to come up with accreditation standards for sex offender treatment program like MSOP; is that correct?

A. I did.

Q. And if someone were sort of -- Or is there an organization out there that -- that, you know,

someone can look to, to figure out, you know, what best practices might be?

A. I think the closest you can come to accreditation process -- because there are accreditation systems in Canada and in the U.K., and so those are sort of the -- I would say, the most useful guides that we have at this point.

Q. Well, in the United States, there's an organization called the Association for the Treatment of Sexual Abusers; is that right?

A. Yes.

Q. Now, is that one place that you would look to?

A. Well, it's one place that we look to; but it has more to do -- more specifically to, again, practice standards and guidelines. It doesn't necessarily speak specifically to structure of a civil commitment program. But, yes, it does provide -- in the field in general, it is the most established standards of practice that we have in the field.

Q. And I guess I've noticed in your reports that you comment on the fact that there are a good number of MSOP employees that attend the ATSA conferences.

A. Yes.

Q. Well, as Mr. Goodwin led you through a couple of your prior reports -- specifically I'm talking about Exhibits 2, 3, and 4 -- he pointed out some sentences here and there in the report, where you and the others made recommendations or identified areas of concern.

Do you remember all of this testimony --

A. Yes.

Q. -- that just happened?

Is it fair to say that, notwithstanding the issues that Mr. Goodwin has identified, you know, in these sentences located within your longer reports, that, notwithstanding those things, it's still the three -- your opinion at least, that the

program operates within best practices. Right?

A. Yes.

Q. Now, I know you testified about the other

programs around the United States and around the world, that you've evaluated.

Whenever you evaluate a program, have you ever evaluated a program and said, "This is a perfect program, there are no" -- "I have no recommendations for improvement"?

A. No.

Q. It's fair to say, Mr. Haaven, in your mind, for a program to operate within best practices, it doesn't have to be absent any kind of recommendation for improvement; correct?

A. Correct. In fact, I would go on to say that to be within best practice is to have an advisory component to where you're getting feedback as to other areas to where there could be potentially clinical drift or program drift in a way that it could in any way potentially compromise the integrity of the programming.

Q. So you actually -- If I understand your testimony correctly, it's your position, Mr. Haaven, that the fact that MSOP has brought the three of you in to evaluate them on an annual basis is actually consistent with best practices?

A. Yes.

Q. How is phase 1 of the MSOP program reflective of current research or experience or practices in the field of sex offender treatment?

A. Again, it's -- it's -- it's -- it's congruent with what is -- what the literature would expect, and that is preparatory. You're trying to identify, one, preparation of -- that the person is treatment ready, in a sense. It's the phase of motivation, the person identifying what their goals might be and looking forward. So in that sense. And that's why I think I clarified that it's more than just compliance with the rules; that it's

preparatory process and the person becoming engaged in the treatment process, before you start moving more specifically into sex offender specific focus.

Q. So, in your experience and your opinion, is the treatment phase design at MSOP consistent with other treatment program designs in other civil commitment programs?

A. With the ones that I've observed, yes.

Q. What do you say to people who may argue that they don't get any sex offender treatment in phase 1 of the treatment program? Do you agree or disagree with that statement?

A. I disagree.

Q. And why do you disagree, in your professional opinion?

A. Well, because, again, I think sometimes it's not clearly understood what phase 1 is, again. It's preparation, it's motivation, it's engagement. It's not necessarily learning specific skills how not to offend; that's the next phase. But to move into that phase without first having the person prepared, motivated, and involved in the process, is contraindicated.

Q. And so when you said compare -- Your -- And so your testimony then, sir, is that the 84 percent treatment participation rate compares favorably with other programs?

A. Other civil commitment programs.

Q. Broadly speaking -- I know that you have some recommendations about skill building,

psychodynamic approach, things like that; but, broadly speaking, do you have -- do you see significant problems with the program manual at MSOP?

A. No.

Q. The theory manual at MSOP?

A. And, again, you're talking -- you're just talking about significant concerns? No.

Q. With respect to the goal matrix, we talked about the Likert scale and things like that, is -- is the goal matrix something you'd expect to see at a program like MSOP?

A. Yes.

Q. And that goal matrix is, in your opinion, professional opinion, consistent with best practices in the field?

A. Yes.

Q. Throughout your report, the three of you looked at 12 areas; right?

A. Um-hum. Yes.

Q. And how did you decide what those 12 areas would be?

A. Again, those 12 areas that we're looking at, we're drawing, again, from the literature and worked in the "what works" literature, criminology

literature.

Q. And I'm -- I'm going to ask you to just speak for yourself: But when the -- when you're looking at these 12 areas and you're saying the program operates within best practices, what are you judging that against?

A. Well, it's -- it's a range of things; because, first of all, we have the criminology literature: So within those areas of practice, there's certain kind of general expectations. We then look at more specific treatment strategy practice standards, and that's where we utilize the Association for Treatment of Sexual Abuser standards, which are maybe the most recognized standards in the field. The third area that we look at is what do other civil commitment programs do, by looking at the surveys from the civil commitment programs as to level of service, participation, or a range of things that they put out in their surveys, so we have an idea. And then we also look at what is general consensus within -- within the field itself. And the fourth thing is from our own observations of other -- comparing it to other programs. So that's really kind of the basis.

I -- There's really only one other piece

to this, and that's the important piece, and that's our familiarity with the accreditation process of programs like this, which are in the U.K. Again, Robert McGrath and William Murphy have been specifically contracted and worked with the accreditation system in the U.K. I have worked as a consultant in special needs process in getting their adapted programs up to meeting accreditation standards. So we have that familiarity also with accreditation system, so that's where we draw from.

Over the last six, seven, or eight times you've reviewed the MSOP program, each time you spend a day or two in St. Peter and a day or two in Moose Lake; right?

A. Yes.

Q. And so you consider yourself familiar with the physical plant of both facilities?

A. Yes. We're provided a tour, as well as we make requests to see particular areas. So, yes, we're very familiar with all of the plant area.

Q. And you're familiar that, with respect to phase progression -- whether it's phase 1, phase 2,

phase 3, or even CPS -- that there are different levels of liberty, for lack of a better term that I can think of off the top of my head, among those groups of clients at MSOP. Is that accurate to say?

A. Yes.

Q. And so the complaints, say, from someone who's in phase 1 at MSOP about their liberty and the rules they live by would be different than someone who lives at CPS. Is that fair to say?

A. Yes.

Q. And, in fact, one might expect that the difference -- or that the complaints about liberty and rules, and things of that nature, would be different among someone who -- or between someone who's at phase 1 at Moose Lake and even phase 2 or 3 at St. Peter; correct?

A. Yes.

Q. Going back to the goal matrix: In one of your reports, you said something along the lines of the goal matrix clearly links the key dynamic risk factors that should be addressed in an effective sex offender treatment program to MSOP's phases of treatment.

Does that sound like a conclusion you would have reached?

A. Yes.

Q. And, I guess, in looking at your reports and listening to your testimony in response to Mr. Goodwin's questions, you -- it sounds to me that the -- and so correct me if I'm wrong, but it sounds to me that the concerns you have sort of deal with the implementation of the goal matrix or how people are being scored, for example?

A. Yeah. That was one of the concerns we had, more significant concerns we had.

Q. But not necessarily with the structure of the goal matrix, the structure of the goal matrix itself?

A. That's a fair statement, yes.

Q. Is it accurate to say that you've actually seen improvement in the area of concern that we just talked about over the years?

A. The question was: Have we seen improvement? Yes.

Q. Let's look at Exhibit 4, page 35, your -- your site visit report. And just for authentication purposes, Mr. Haaven, why don't you page through to the end and confirm for me that this is in fact your report dated January 7th, 2014.

A. Yes, this is.

Q. Well, with respect to program sequence, if we look at page 39 through page 40, in that first sentence, you note that "the overall program sequence is logical and appears to be responsive to clients' treatment needs and learning styles."

Is that accurate? To the best of your knowledge as you sit here today, is that still accurate?

A. Yes.

Q. And in several of your reports, you also note -- you have praise for the recreation, education, and vocational services program; right?

A. Yes.

Q. In fact, I think, in one of your reports, you identified the vocational program as a "model program and the strongest one we have seen in a civil commitment program."

Does that sound familiar to you?

A. Yes.

Q. Is that still your opinion, as we sit here today?

A. Yes.

Q. Give me a sense of what -- What's the value of a recreation, education, and vocational services program at a -- at the MSOP?

A. A couple of things. One is, particularly in institutional settings, you want to have an array of diversional activities to, in a sense, sort of provide a quality of life experience. It speaks, again, to anyone that's involved in a treatment program or a change process needs to have basic needs in their life met; so the diversional aspect is one important piece, again, for preparedness for change.

The second part to that is that it gives an opportunity to see how skills learned and the treatment -- more specific treatment activities are generalized to, again, more normative types of behaviors and more disinhibited types of behaviors, to see what effect the treatment might be having.

Q. Now, again, vocational services was one that you pointed out as a model program in the country.

What about vocational services in particular at MSOP makes it a model program?

A. Well, one, most of the programs you see, they're sort of doing -- making -- building widgets; and it's -- and, instead, their program is actually doing some really interesting contracts, meaningful -- work that is seen as meaningful by the clients

that are working in them. Their compensation, paid compensation, the way it's done. Also the training they receive. And, really, the kind of -- what we saw as skill building within the vocational, beyond just the skill itself, of how to get along with the boss, how to develop work type of behaviors.

So we saw on many levels, from a therapeutic perspective as well diversional perspective as well as a skill opportunity perspective, that they're actually learning some marketable skills when hopefully they would get out.

Q. Is a vocational program, in your view, I mean, is that part of a treatment -- a sex offender treatment program?

A. We usually do not see it specified as one of the components of a sex offender treatment program, but yet it would be rare to find someone working in our business that wouldn't say vocational training is an important part -- which is sort of a contradiction, in a sense, but in fact it's very important.

Q. Because it teaches the skills that you just talked about?

A. Right. And it's a generalizing of those skills to a -- to a marketable profession. And

especially working with men, to which much of their identity is associated with their value and worth in the workforce, it has -- it's a significant part of the change process.

is what we've marked as Exhibit 6.

Do you recognize that document?

A. Yes.

Q. What is it?

A. It's, again, our site visit report from 2009.

Q. And is this the document that you and the two others prepared?

A. Yes.

Q. If you look at page 4, in the second paragraph, you'll note that there's some language that says: "The program has been sensitive to responsivity issues." Do you see that?

A. Yes.

Q. "The MSOP has developed specific programs for those high in psychopathy, for young adult offenders, for those with significant mental health issues, and those with lower IQ and impaired learning ability." Correct?

A. Yes.
Q. Now, I know that was five years ago. Is that still your opinion today?
A. Yes.
(Exhibit 7 marked.)
Q. BY MR. IKEDA: Mr. Haaven, in front of you is what's been marked Exhibit 7.
Do you recognize that document?
A. Yes.
Q. And what is it?
A. It's our site visit report for 2010.
Q. And if you look at page 4 -- This is the language that I asked about earlier, so...
"Since the last site visit, the program has finalized and implemented the goal matrix for phases 1, 2, and 3. This document clearly links the key dynamic risk factors that should be addressed in an effective sex offender treatment program to MSOP's phasing" -- "phases of treatment."
Did I read that correctly?
A. Yes.
Q. And that is your opinion still today?
A. Yes.
Q. One of the things that you identified in this report is you questioned whether two-hour group

-- whether two hours of group sessions were effective and appropriate for learning style.

Do you remember that --

A. Yes.

Q. -- in the alternative program?

A. Yes.

Q. Do you know whether MSOP has done anything about that?

A. They reduced the length of the group time.

Q. You also, the three of you, opine in the next paragraph on the use of the behavior therapy unit and the high security unit. And you've believed that, at least as to the high security unit, length of stay was appropriate for the client population in the MSOP.

That -- That is your conclusion; right?

A. Yes.

Q. In every year of your reviews, at least going back to 2009, one of the -- We can move along. You can put that Exhibit aside.

One of the things with respect to administrative structure and program organization is the three of you have consistently used language that says "a strong administrative structure is in place and processes ensure ongoing staff

communication." Correct?

A. Yes.

Q. And so that's something -- a theme that you saw throughout your reviews?

A. Yes. That's a area we give attention to.

Q. So fair to say that the -- Ms. Hébert is the clinical director?

A. Yes.

Q. And she is one of the people that you think is part of the strong administrative structure?

A. Yes.

Q. And Nancy Johnston as well?

A. Yes.

Q. With respect to the issue of community outings, is it your testimony that one would expect to see community outings happen around the time that MS -- that it happens in MSOP's program?

A. Yes.

Q. So with respect to that issue, you think that MSOP's policy is consistent with best practices?

A. Yes.

Q. As part of your review, you've talked about how you also review some client files; right?

A. Yes.

Q. And one of the things that you were asked about earlier was, "Well, where" -- "Where would someone find positive things about a client at MSOP?"

Isn't it true, Mr. Haaven, that in fact there are positive things that are said about clients in progress notes?

A. Yes.

Q. And there are often positive things that are said about clients in their quarterly and annual treatment reports; right?

A. Yes.

Q. When the three of you go to MSOP for your site visits and to prepare your reports, your testimony is that you have complete access to both the facility and records?

A. Yes.

Q. Have you ever been denied access to a part of MSOP when -- when you asked for it?

A. No.

Q. Have you ever been denied a file or a record when you've asked for it?

A. No.

Q. And is it up to the three of you to determine what to review?

A. Yes.

Q. What to write your report about?

A. The only end -- There's two parts: As to what we're going to write our report about, included in that report might be some specific questions that they want us to respond to as problem areas that they're having concern with, that we could give additional consultation to. That would be the only addition to what we're going to be reviewing.

Q. What do you think about that, the fact that MSOP asks you to help them problem solve with -- with these problem areas?

A. Well, I think, every time that we've done the debriefing with all staff afterwards, we share with them that this is rather unique that somebody would invite you in to snoop around in your back yard and give you total access to find any dirt. And so that's rather unique but also an important piece of the programs like this; because you can have drift in issues that can go, you know, unaddressed. And so we try to certainly let the program know that's a -- that's a very powerful kind of intervention that they've introduced.

Q. BY MR. IKEDA: Mr. Haaven, in front of you is what's been marked as Exhibit 8.

Do you recognize that document?

A. Yes.

Q. What is it?

A. It's our site visit report for MSOP for 2012.

Q. And so that's the report that you and the two others drafted; correct?

A. That's right.

Q. BY MR. IKEDA: So, Mr. Haaven, are you familiar -- I think in your December 2012 report, so that's Exhibit 8 that you have in front of you, you -- A couple of the things that you identified in the "facility and treatment environment" section, so we're looking on page 12 and 13 --

A. Yes.

Q. -- is you testified about how you and the two other experts were skeptical about the AMS, how useful the AMS would be, and it turned out to be positive. Right?

A. Yes.

Q. And then one of the other things you identified was clients -- if you look at the last sentence of the second paragraph: "Clients are also being allowed to choose roommates with staff approval, which the clients also see as positive."

Do you see that as a positive development for MSOP?

A. Yes.

Q. And why is that?

A. Well, again, I think that who you live with is a very significant decision that a person is allowed to have.

Q. Does that go to sort of the theme that we had talked about earlier regarding the softening of MSOP?

A. Softening of the environment and the empowering, clients feeling more empowered.

Q. Because, in fact, in January -- in your January 2014 report, in that same section, you talk about how the environment is less restrictive and clients have more freedom of movement; right?

A. Yeah. You said 2014?

Q. January of -- So that would be --

A. Oh, yeah.

Q. -- your 2013 report?

Q. Do you see that at other programs? Specifically when you were at Wisconsin, did they use double bunking?

A. Boy, I can't remember now. All I know is some -- most programs had multiple housing and double bunking. Some do not, but my experience is that the majority have that, but I'm trying think.

Let me think here. Wisconsin? It seemed to me in Wisconsin most of the housing was single.

familiar with any person in the MSOP program, who has been discharged from the program without participating in treatment?

A. No.

Q. Okay. We can move on.

So, we were talking about phase 1 earlier, and Mr. Ikeda, when he was questioning about you that, he -- I believe your response was along the lines of that phase 1 serves as a preparatory

process before going to sex offender specific treatment. Is that --

A. Yes.

Q. -- accurate?

So is sex offender specific treatment -- Outside of the benefits of the rule -- learning to follow rules and the structure, is there a sex offender specific treatment offered to a client in phase 1 at MSOP?

A. Well, maybe I should -- Let me -- Let me clarify.

When I say that it's more focused sex offender specific, if we looked at "is it part of a sex offender programming?" certainly the first stage is, because the first stage is, again, motivation and involvement and engagement of the individual in the process. So, in a sense, that's the sex offender specific focus. When you move to the next phase, it's focusing more on the specific strategies on how one manages their sexual offending pattern itself. So that's sort of the distinction between the two.

Q. But that sort of treatment regarding sex offender specific patterns and offending, is that offered in phase 1 at MSOP, as far as you know?

A. My understanding is that's not the intent.

H

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